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THESIS

HEALTH CARE REFORM AND THE DEFICIT, 1993-1996

by

William J. Gieri

March 1997

Principal Advisor:

Richard B. Doyle

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HEALTH CARE REFORM AND THE DEFICIT, 1993-1996

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Submitted in partial fulfillment
of the requirements for the degree of

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from the

NAVAL POSTGRADUATE SCHOOL

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ABSTRACT

Health care reform in the 103rd and 104th Congresses has run the gambit from extremely ambitious to less than ambitious undertakings. Proposals have engendered partisan debates, because of the scope and complexity of the issues involved and their implications for the federal deficit. Estimating the budget consequences of health care reform has become critical because of the strong link between health care programs and the growth in the deficit. This thesis examines the major health care reform proposals considered by Congress during the period 1993-1996. These included the comprehensive bills considered in response to President Clinton's proposed overhaul in 1993-94, the cuts included in the Republican-led balanced budget plan in 1995 and the Kassebaum-Kennedy Bill, which became law in 1996. In each case, the thesis examined the deficit situation facing Congress at the time health care reform was engaged, plans to address the deficit, and the impact of each health care reform on the federal deficit. Data was obtained from congressional reports and periodicals, journals and Congressional Budget Office documentation. The major finding was that health care legislation which portends minimal impact on beneficiaries, providers and the deficit is much more likely to succeed, while legislation which has a much broader effect will not receive the same support.

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I. INTRODUCTION

The debate surrounding health care and health care reform in the U.S. is not new. It formally dates back to the administrations of Roosevelt (1932-1945) and Truman (1945-1952). In 1974 health care reform headed the domestic policy agenda of the United States. Then, much as today, the central issues debated were: what is the government's role in health care? Should the United States have a national health insurance program? Who should be covered? Should employers be required to provide health care plans for their employees? Should taxes be raised to cover the additional costs of providing health care? (Banks, 1994, p. XV)

Today, 20 years latter, we find ourselves revisiting these same issues. Health care again tops the legislative agenda for the President and Congress, in large part because of the continued rapid growth in national health care expenditures, the public perception of the relationship between the deficit and the cost of health care, and public realization that inaction on the part of our elected officials will result in the demise of the Medicare security blanket for elderly citizens.

Until this century, few people lived into old age. Fewer than one percent of the world's population was 65 years of age or older in 1900. Today, that number has grown to six percent worldwide and 12 percent in the United States. Estimates are that by the year 2050 nearly a

quarter of Americans will be 65 years of age or older.
(Mathews, 1996, p. 6B)

In 1992, health care spending absorbed 14 percent of the gross domestic product (GDP), up from 5.9 percent in 1965. Without some sort of reform, health care spending is expected to rise to 19 percent of GDP by the year 2000. Almost one out of every five dollars spent by Americans will go to health care, robbing workers of wages, straining state and local budgets and adding billions of dollars to the federal debt. (President's Report, 1993, p. 7) "The budget projections indicate that Medicare outlays will rise from \$176 billion in 1995 (2.5 percent of GDP) to \$344 billion (3.5 percent of GDP) in 2002 and to \$460 billion (4 percent of GDP) in 2005." (Aaron, 1995, p. 2) The Congressional Budget Office (CBO) now projects the federal deficit will climb to \$244 billion, or 2.7 percent of GDP, by 2000. However, if spending for the major health entitlements could be held to its current share of GDP, the federal deficit would be substantially less in 2000.

A. MAJOR FEDERAL HEALTH CARE PROGRAMS

Medicare and Medicaid are the major health care programs of the federal government, and both are entitlements.

1. Medicare

Medicare was enacted as an amendment to the Social Security Act in 1965. It was the result of several factors. First, there was the growing concern that elderly citizens

were vulnerable to the high costs of catastrophic illnesses, primarily due to the paucity of insurance and the greater health needs of the elderly. In the early 1960s, before Medicare, only about half of older Americans had any health insurance, as compared to 75 percent of those below 65 years of age. Some seeking insurance were denied on the basis of age or pre-existing conditions, others simply could not afford insurance. Second, the elderly were becoming a powerful political influence, not for the size of the elderly population, but as a result of the strong bipartisan political support they enjoyed in all parts of the country. (Banks, 1994, p. 5)

Medicare covers all Americans and permanent residents 65 years of age or older, persons with end-stage renal disease (ESRD), and those receiving Social Security Disability Insurance (DI) benefits for at least two years. It is divided into two components: Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B).

Part A helps pay the cost of hospital inpatient and skilled nursing care, and is considered an earned benefit for most people, requiring no premium upon eligibility. It is funded by current employees and their employers, each paying 1.45 percent of the worker's salary (self employed workers pay 2.90 percent) to the Hospital Insurance Trust Fund. Part A benefits are considered to be earned, much as those from a conventional insurance policy, by the payroll tax deductions beneficiaries and their employers contributed to these programs.

Part B is voluntary insurance for physician services financed through monthly premiums (\$46.10 in 1995), which cover about 25 percent of costs, and federal tax revenues, which cover the remaining 75 percent. In 1994, over 98 percent of elderly and 88 percent of disabled beneficiaries elected to participate in Medicare Part B (National Academy on Aging, 1995, p. 1). Part B generally pays 80 percent of the physician and outpatient services after the annual \$100 deductible.

Coverage includes physician services, laboratory and other diagnostic tests; X-ray and other radiation therapy; outpatient services at a hospital, rehabilitation facility, or rural health clinic; home dialysis supplies and equipment; ambulance services; physical and speech therapy; mammography screening and screening pap smears; and outpatient mental health services (50 percent of approved amount only). (National Academy on Aging, 1995, p. 2)

Neither component of Medicare covers beneficiaries for prescription drugs, non-surgical dental services, eyeglasses, hearing aids, or long term care (i.e., that care provided by nursing facilities in the community or at home). Medicare beneficiaries face cost-sharing in the form of premiums, deductibles, and coinsurance, as well as the cost of services and products not covered by Medicare. There is no limit to the out-of-pocket expenses elderly Medicare recipients can incur. Unlike most private insurance, Medicare does not cap beneficiaries' out-of-pocket expenses. "In 1994, older persons (excluding those living in nursing homes) on average spent \$2,519 on health care or 21 percent

of their average household income." (National Academy on Aging, 1995, p. 2) However, due to the disparities between the amounts paid and the formula for making payments, older Americans in 1995 were receiving more than ten times as much in Medicare benefits as they and their employers contributed in taxes, including interest on those contributions. (Peterson, 1994, p. 44)

2. Medicaid

Medicaid is the chief provider of health care for the more than 25 million poor adults and children. Unlike Medicare, Medicaid is a joint federal-state means-tested program available to various groups of low income Americans. Means-tested programs are those in which a recipient's income is taken into account when determining eligibility for benefits. Women and children receiving benefits under the state-federal Aid to Families with Dependent Children (AFDC) program automatically qualify, as do low-income blind, elderly and disabled people getting cash assistance under the Supplemental Security Income (SSI) program, and low income children and pregnant women. States, under a federal waiver, may cover additional persons who face crushing medical costs but whose income or assets are too great to allow them to qualify for SSI or AFDC. Thus the total number of persons eligible for Medicaid benefits is determined by each state.

Medicaid is jointly funded by the federal and state governments. The federal government pays about 57 percent of the Medicaid costs, while the states pay the remaining 43

percent, both out of general tax revenues. States administer the program and set specific eligibility requirements and benefits packages. Thus, unlike Medicare, there is a wide ranging composition of benefits packages depending on the population and wealth of the individual state. States such as California and New York offer comparatively generous benefits, while states such as Mississippi and Arkansas have less generous packages. (Banks, 1994, p. 7)

Most Medicaid spending goes to the elderly in the form of long term nursing home care and rehabilitation, and the non-elderly disabled. (Hager, 1993, p. 24)

B. FEDERAL SPENDING ON HEALTH CARE

Medicare and Medicaid are two of the fastest growing federal programs. Medicaid's growth rate averaged 17.8 percent between 1988 and 1995 (Fraley, Jun 10, 1995, p. 1638), and grew 31.5 percent between 1991 and 1992. During the same period, Medicare's growth rate averaged 10 percent, and grew 13.9 percent between 1991 and 1992 - roughly four times the rate of inflation and faster than any other federal entitlement, except Medicaid. (Hager, Jan 2, 1993, p. 22)

By comparison, general health care costs grew about 11 percent, and the consumer price index grew 3.1 percent, between 1991 and 1992. (Rovner, 1993, p. 28) In 1992, federal, state and local governments paid nearly half the nation's total \$832 billion health bill. The federal

government footed slightly more than 31 percent of this \$832 billion bill. Almost three-fourths of that is spent on Medicare and Medicaid payments. (Rubin, 1993, p. 955)

Figure 1 depicts the rising costs of the two largest federal health care programs.

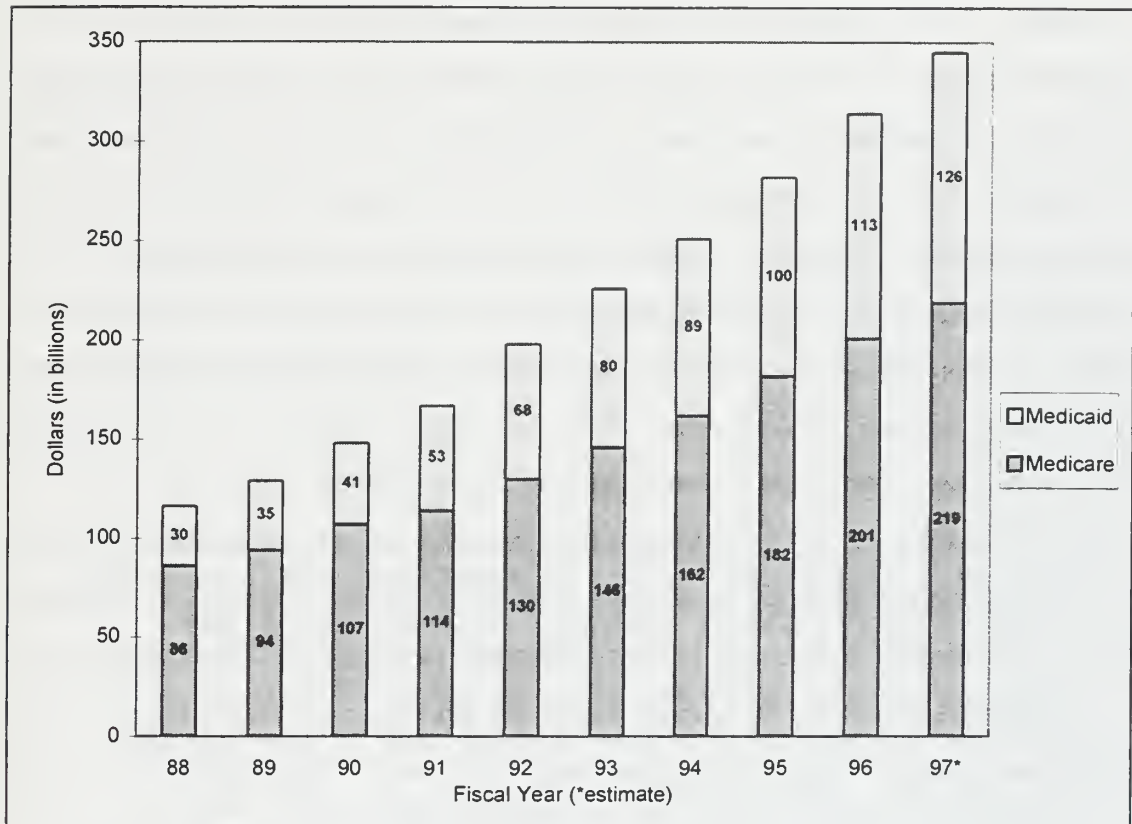


Figure 1. Rising Medicare and Medicaid Costs
Source: Congressional Budget Office, Aug 1996

Although there are diverse reasons for the growth in health costs in general, and Medicare and Medicaid in particular, most analysts agree that some key elements are common to all three. The two biggest health care cost drivers are technology and demographics. (Rovner, 1993, p. 28)

Technology boosts health costs because it provides doctors and hospitals new procedures and tests they can perform on patients, which are usually more expensive. The rapid technological change in health care has certainly improved the quality of service to patients. "However, because third-party payments encourage overuse of new technology, new technology has likely been overdeveloped, beyond the point at which its marginal benefit equals its marginal cost." (Hyman, 1996, p. 302) Additionally, the retrospective payment system used by private insurance providers reduced the incentives for the research and development (R & D) sector to invest in developing medical care techniques that were of both higher quality and cost effective. (Weisbrod, 1991, pp. 527-529)

The effect of health care insurance on incentives for R & D depends on the operational definition of health care—that is, on the boundaries of the insurance contract. Health insurance contracts do not offer the option of coverage only for particular subsets of technologies, such as those available at a given point in time. The more broadly health care is interpreted under the contract, and the more responsive it is to changes in technology, the broader the range of activities over which insurance will encourage R & D. If insurance coverage is defined, as it has been, to encompass new technologies regardless of the costs involved, and to encompass an ever widening concept of health care that is, itself, responsive to the development of new technologies, the R & D sector will continue to face incentives that reward costly new measures relative to cost-reducing innovations. (Weisbrod, 1991, pp. 529-530)

When new technology is developed and utilized beyond an efficient level, then more than an efficient amount of capital will be used by the health care industry. This is a common phenomenon with hospitals competing on the basis of the latest technology and comfort, rather than seeking to economize on cost and keeping patient prices down. This eagerness of doctors and hospitals to utilize and prescribe the wonders of modern technology has contributed to the rise of health care expenditures in the United States. (Hyman, 1996, p. 302) "A magnetic resonance imaging machine may or may not provide better information than a plain old X-ray, but it is indisputably more expensive." (Rovner, 1993, p. 28)

As America ages, its total health care bill rises, because the elderly consume more health care services than younger adults. This affects Medicare disproportionately since most of its 38 million beneficiaries are over the age of 65. However, it also affects Medicaid costs, because Medicaid pays for the long term nursing home care. Indeed, while the elderly represented only 12 percent of Medicaid's nearly 37 million recipients in 1996, they consumed one-third of all Medicaid spending, mostly for nursing home care. (CBO, 1996, p. 435)

Figure 2 depicts the top twelve entitlement spending programs of the federal government, ranked by size. Entitlement programs now account for more than half of the federal budget, and continue to grow. The sheer size and growth of these programs necessitates their review when

looking for ways to control the deficit. Medicare and Medicaid combine size with explosive growth rates to make them the two most serious budget problems.

Rank/Program	Actual '91 Outlays (billions)	Avg. Annual Percentage Change	
		1985-91	1991-97
1. Social Security	\$267	6.2	5.8
2. Medicare	\$114	8.6	11.6
3. Deposit Insurance	\$66	NA	NA
4. Medicaid	\$53	15.0	15.8
5. Federal Civilian Retirement	\$37	6.2	6.9
6. Unemployment	\$25	8.0	0.7
7. Military Retirement	\$23	6.6	5.7
8. Food Stamps	\$20	8.1	4.0
9. Supplemental Security Income	\$15	9.1	9.4
10. Family Support	\$14	7.8	5.3
11. Veterans' Benefits	\$14	2.4	4.6
12. Farm Price Supports	\$10	-9.0	-1.4

Figure 2. Top Entitlements 1991 "From (Hager, 1993, p.26)"
Source: Congressional Budget Office

Getting control of the federal deficit has become tied directly to the extraordinarily difficult problem of containing health care costs. In the words of Senator George J. Mitchell (D-Maine), former Senate Majority Leader, "I do not believe that we can in any meaningful way address the deficit unless and until we address health-care costs." (Rovner, 1993, p. 28)

C. THE FEDERAL DEFICIT

"The budget deficit is the central problem of the federal government and one from which many of the country's

most difficult problems flow." (Washington Post National Weekly Edition, 1995, p. 24) Why have deficits become such a problem for budget decision makers? Simply put, spending has been growing faster than revenues. Revenues have remained nearly constant as a percentage of GDP (about 19 percent) since the 1960s. However, outlays have grown from less than 18 percent of GDP in 1965 up to 24 percent in 1983 before falling to 21 percent today. Much of this growth in spending has come from Social Security, Medicare, Medicaid and interest payments on the debt (see Figure 3). (OMB, 1996, p.1)

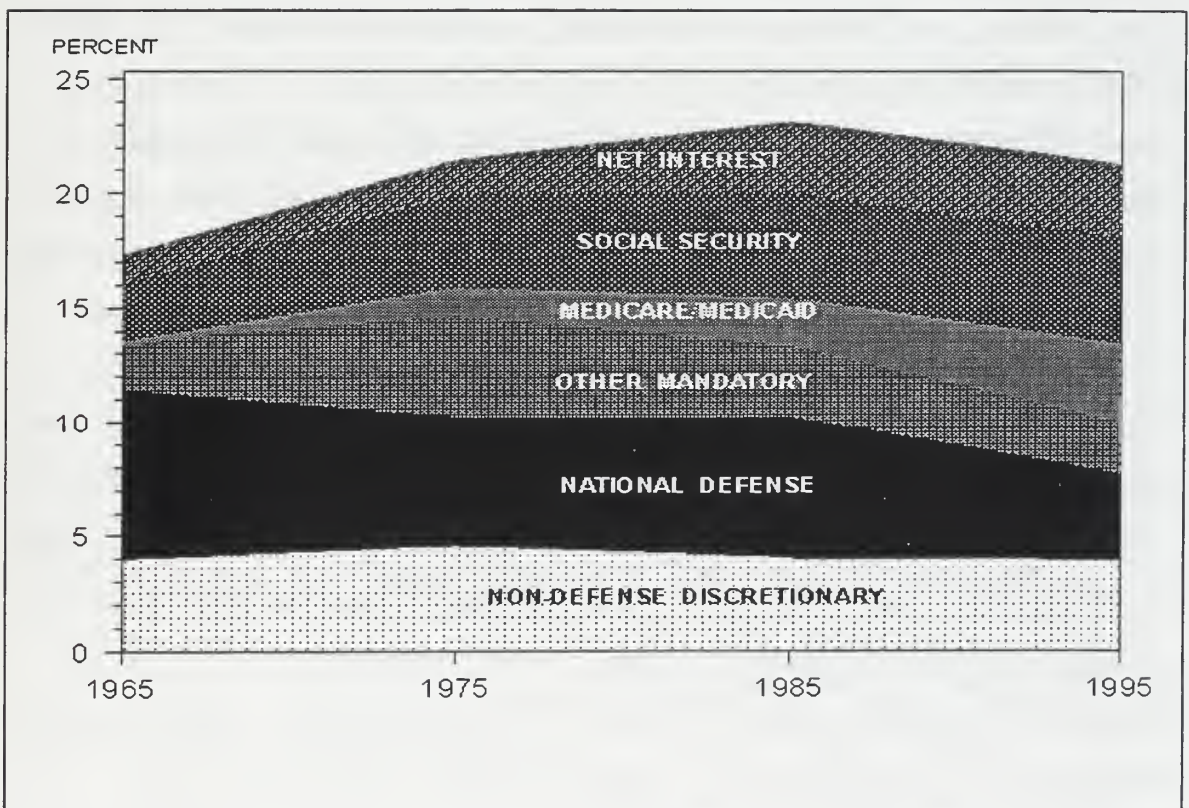


Figure 3. Outlays as a Percentage of GDP "From (OMB, 1996, p. 2)"

In the 1990s, Congress and the administration have made noticeable strides in reducing the federal deficit, whether the deficit is considered in absolute numbers or as a percentage of GDP. 1996 was the fourth straight year in which the deficit declined. According to the Congressional Budget Office (CBO), the deficit declined from \$254.7 billion and 4.1 percent of GDP in FY1993 to \$107.3 billion (the smallest since 1981) and 1.4 percent of GDP (the smallest since 1974) in FY1996. However, both officials from the Office of Management and Budget (OMB) and CBO predict that beginning in FY 1997, the deficit will again begin to rise. Administration officials predict the deficit for FY1997 will be \$144 billion (about two percent of GDP). (CNN, 1996, p. 1)

The CBO projects that under current policies and current expectations about the economy, the deficit will creep up from just under two percent of GDP in 1997 to just over three percent of GDP in 2006. But the real trouble occurs beginning about 2010, when the first wave of the baby-boom generation reaches retirement age and "ushers in an era of unprecedented pressure on federal spending for the Social Security, Medicare and Medicaid programs." (CBO, Aug 1996, p. 1) At that time the number of people working and paying taxes to support those and other programs will grow much more slowly than the rate of baby-boomers retiring and adding to the programs. Under current policies, the deficits realized by the addition of the baby-boomers to Social Security, Medicare and Medicaid will easily dwarf

even the largest deficits experienced to date. Indeed, "by the middle of the next century, they threaten to drive the federal debt to levels that the economy could not possibly sustain." (CBO, Aug 1996, p. 1)

Projecting the deficit requires numerous assumptions concerning such variables as the state of the economy, unemployment, inflation, federal outlays and revenues. Thus, future predictions of the deficit are only as good as the prediction of the underlying independent variables. The further into the future assumptions are made to characterize these variables, the greater the probability for errors to arise, translating to errors in the dependent variable, the deficit. However, deficit predictions are a useful tool for evaluating the budgetary impact of proposed legislation, and the consequences of failing to correct existing legislation. Table 1 provides CBO's projection of future budget deficits out to the year 2006.

	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05	FY06
Deficit	\$171	\$194	\$219	\$244	\$259	\$285	\$311	\$342	\$376	\$403
% GDP	2.2	2.4	2.5	2.7	2.7	2.9	3.0	3.1	3.3	3.3

Table 1. CBO Budget Outlook Under Current-Policy Economic Assumptions with Discretionary Inflation (billions of dollars) "From (CBO, Aug 1996, p. 2)"

Table 1 indicates that without some sort of action by the Congress and Administration, the federal deficit will again begin to grow, after four straight years of decline. Based on the current ten year outlook, at least one message

is clear: any serious efforts to reduce the deficit significantly will have to include substantial policy changes. These changes must go well beyond continuing to restrain spending for annual appropriations, or the so called discretionary programs. (CBO, Aug 1996, p. 3)

Annual appropriations, by Congress, generally act to control and restrain discretionary spending. In 1996 this spending accounted for \$530 billion, or approximately one third of all federal spending, and has been shrinking over the past 30 years. Mandatory spending, including entitlements and net interest on the debt, accounted for \$1 trillion in 1996, or nearly two thirds of all federal spending. (CBO, Aug 1996, p. 5) The sheer size of mandatory spending and its average annual growth rate of 6.8 percent necessitate action by the Administration and the Congress to reduce spending to gain control of the deficit. Politically feasible reductions in discretionary spending simply are not likely to be sufficient to control the deficit.

D. SCOPE OF THIS THESIS

This thesis will examine the major health care reform proposals Congress dealt with during the period 1993-1996. These include the ten reform proposals which emerged from committees during the 1993-1994 reform period, the reforms incorporated in the failed 1995 Reconciliation Bill, and the reform bill passed in 1996 (the Kennedy-Kassebaum Bill). In each case, the deficit situation facing Congress at the time health care reform was engaged and plans to address the

deficit will be explained, as well as the impact of the major health care reforms on the federal deficit. The central purpose of this analysis is to clarify the relationship between the deficit and congressional health care reform measures. This thesis will not examine proposals not specifically addressed by Congress, nor will it attempt to advocate any specific reform plan or package. From this analysis, conclusions and implications will be derived to determine possible lessons learned which may be used for future reform packages taken up by Congress.

E. BENEFITS OF STUDY

This thesis will address the financial constraints involved with health care reform during a period characterized by resistance to increasing the federal deficit. Medicare, one of the fastest growing segments of the federal budget, received particular attention in the reform debate, especially in the Republican-controlled one hundred and forth Congress. This thesis will provide insight on the complex issue of health care reform, and lessons learned from previous attempts at reform which will benefit future reform attempts.

II. THE CLINTON HEALTH CARE INITIATIVE, 1993-1994

The 1992 Presidential elections ushered in a new government era. President-elect, Bill Clinton, "proclaimed that the defining work of his presidency would be the overhaul of the health-care system and the elevation of health care to a civil right." (Rubin, 1993, p. 7) His crusade was that every American, regardless of age or current health status, would have access to comprehensive and affordable health care. This promise set the legislative agenda that consumed the 103rd Congress.

Donna E. Shalala, President-elect Clinton's choice for secretary of Health and Human Services, succinctly stated the new administration's position during Senate confirmation hearings. "No problem afflicts more families around the kitchen table more than the radical escalation of health-care costs, and no problem demands our greater attention as policy-makers and public servants." (Zuckman, 1993, p. 131)

A. FEDERAL DEFICIT OUTLOOK

In January 1993 the U.S. economy appeared to be on the rebound, entering a period of self-sustaining growth. GDP was expected to grow at an annual rate of approximately 3 percent through 1994--approximately three quarters of the expected growth rate for this period in the business cycle following a recession trough. The economy was expected to grow at an average rate of 2.5 percent over the period 1995-1998. Although the growth rate was expected to be below

normal, it would be sufficient to reduce unemployment from around 7 percent, at the end of 1992, to below 6.5 percent by the end of 1994. (CBO, Jan 1993, p. xiii)

The slow pace of the expansion would also help to keep the inflation rate relatively low through 1998. CBO estimated that the rate of inflation would average around 2.7 percent through 1994, and was not likely to rise much through 1998. Additionally, short and long term interest rates were projected to remain fairly constant through 1993, with a slight rise in short term interest rates during 1994. (CBO, Jan 1993, p. 1)

However, the onset of the economic expansion did not portend relief from budget deficits. Deficits were expected to remain at or near \$300 billion through 1994 and then grow larger in the second half of the 1990s. "If the current fiscal course is not changed, 10 years from now the deficit could reach twice today's level." (CBO, Jan 1993, p. xv) The CBO estimated the 1993 budget deficit to grow to \$310 billion - 5 percent of GDP (see Table 2). (CBO, Jan 1993, p. xvi)

	1991*	1992*	1993	1994	1995	1996	1997	1998
Total	270	290	310	291	284	287	319	357
Deficit								

Table 2. Deficit Predictions in billions of dollars, by fiscal year (* is actual) "From (CBO, Jan 1993, p. xvi)."

These budget projections assumed that tax laws and mandatory spending remained unchanged, and that discretionary spending in 1994 and 1995 remained within the spending caps imposed by the Budget Enforcement Act (BEA) of 1990.

These projections painted a grim picture for the Administration and the Congress. Though federal revenues and most major spending programs were projected to grow no faster than GDP, the deficit would continue to spiral upwards. The deficit was being driven by the two major health care entitlements--Medicare and Medicaid--whose costs were exploding. Even if the economy grew one percent more rapidly than CBO predicted, the deficit would still total \$230 billion in 1998, barring any change in revenue laws or mandatory spending. (CBO, Jan 1993, pp. xvi-xvii) CBO stated that "increases in spending for Medicare and Medicaid are the dominant force pushing deficits back up as the 20th century nears its end. . . Without the rapid growth of federal health care spending, the deficits would probably decline steadily as a percentage of GDP." (Statement of Robert Reischauer, 1994, p. 10)

B. DEFICITS AND THE DEBATE

Health care policy was clearly implicated in the federal budget deficit. However, there was no pointed and sustained focus on the deficit consequences of the reform measures debated by the Clinton Administration between February 1993 and congressional adjournment in October of 1994. The deficit consequences of various reform measures

were a result of the nature of the reform problem and media treatment of its deficit implications.

This is not to say that the deficit implications of reform packages were not considered. According to the Office of Technology Assessment, "estimates of the effect of health reform on the federal budget are an important part of the current health reform debate." (Office of Technology Assessment, 1994, p. 1) Furthermore, legislators were frequently delayed in considering important reform bills--and complained about the delays--while the Congressional Budget Office (CBO) estimated the bills' costs.

From a procedural point of view, deficit impacts of the reform proposals were critical to legislative success. The Budget Enforcement Act of 1990 required that any increased spending for an entitlement program be offset by either reductions in other entitlements, new revenues of equal value, or a combination of reductions and increased revenues. This requirement, known as the PAYGO rule, generated significant interest in CBO deficit estimates, the scorekeepers for PAYGO enforcement.

1. Complexity of Issues Involved

As a public policy issue, health care reform involves many things, only one of which is how it affects public finances. Major reform of health care financing significantly changes health-care delivery and would require "trade-offs between patient and doctors, provider and insurer, business and government - some of them impossible to manage." (Rubin, 1993, p. 8) "To make health-care

services available to everyone at affordable rates opens up all kinds of questions about what gets covered, who controls costs and how the health industry is reorganized." (Rubin, 1993, p. 595)

Health care reform is about reconfiguring one seventh of the U.S. economy. That fraction refers to total 1992 public and private spending for health care in this country. At \$832 billion, that was more than 14 percent of GDP, and rapidly growing. CBO's baseline projections indicate national health care expenditures will reach \$1.7 trillion by 2000 (Figure 4). Elected officials are expected to respond to voter sensitivity to any and all parts of the nexus of health-care related issues.

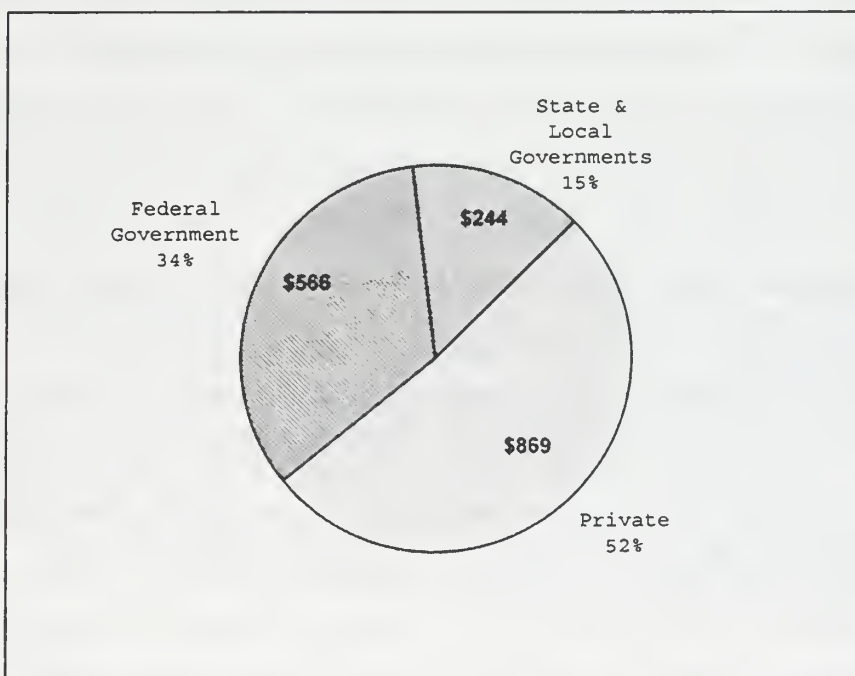


Figure 4. National Health Expenditure by Source Funds, CBO Projections 2000 (\$ billions)
Source: CBO, July 1993, p. 17.

More than 20 percent of federal, state and local revenues are being spent on health care (Cutler, 1994, p. 21). U.S. health care spending exceeds the size of the economies of most countries of the world, approximating the GDP of the UK (Committee for a Responsible Federal Budget, 1994, p. 27).

2. Public Perception

The public's perception of the current health care system is largely influenced by the news media. Newspapers and television horror stories about the health care industry have influenced the public's perception and fostered the demand for complete reconstructive surgery of the system. A March 12, 1993 Wall Street Journal/NBC News poll found that 74 percent of Americans believed that a complete overhaul of the health care system was necessary. Nearly 66 percent said they were willing to pay more taxes to fix the country's health care system. (Rubin, 1993, p. 595)

However, when Americans are asked what taxes they would be willing to pay, they generally pick those that raise the least money. Examples are increased taxes on cigarettes or alcohol ("sin taxes") or an increase in the income tax on those who earn \$50,000 or more. Support for an income tax drops from 61 percent to 29 percent when the increase is on those who earn \$25,000 or more. (Figure 5) (Rubin, 1993, p. 959)

Although there appears to be a clear consensus that the current system is badly in need of repair or overhaul, there is not the same consensus on the vehicle for funding the new

system. This lack of a public mandate set the stage for the health care reform debates of the 103rd Congress.

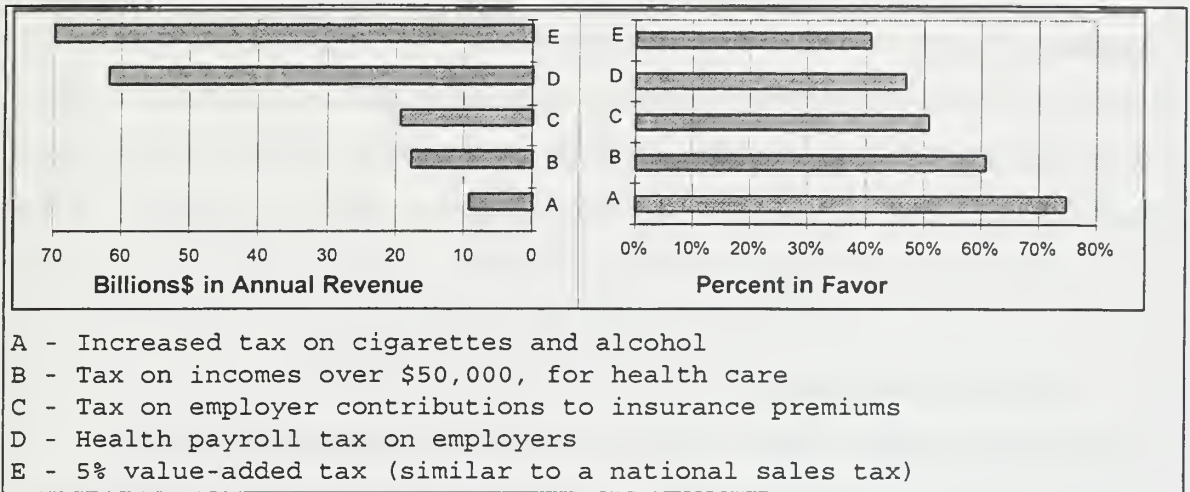


Figure 5. Paying for Health Care: Popularity of Various Tax Options "From (Rubin, 1993, p. 959)" Source: Kaiser Harris Election Night Poll and Joint Tax Committee.

3. Complexity of Health Care System

The complexity of the U.S. Health care system makes finding the deficit implications of health care reform extremely difficult. A Brookings Institute study observed that Americans are served by a "spectacularly complex administrative maze of public, private, and non-profit organizations" that finances and delivers health care (DiIulio, 1994, p. 7).

Federal programs for the old, disabled, poor and the military provide care through Medicare, Medicaid, the VA and DoD subsystems, while private and non-profit providers deliver the majority of that care. Many of the 4.5 million private employers in the U.S. provide health plans, either directly or through insurance companies. There are no fewer

than 1,500 public and private insurers in this part of the health care industry and almost as many (1,350) HMOs and PPOs. States play a key role in regulating insurance companies and administering Medicaid. Professionals in health care--doctors, nurses, and dentists--number 600,000, working in offices, clinics and more than 5,000 community hospitals (Committee for a Responsible Federal Budget, 1994, p. 71).

C. HEALTH CARE BILLS

During the course of the 103rd Congress many health care plans were introduced. Only seven made it through the necessary CBO scoring process before adjournment, in October 1994. Four were reported favorably out of committee, and only one (the Mitchell bill in the Senate) was actually called up for debate (see Table 3).

- | |
|---|
| 1. Clinton |
| 2. Gibbons |
| 3. Mitchell (w/o Employer
Mandate) |
| 4. Michel |
| 5. Mitchell (w/Employer
Mandate) |
| 6. Managed Competition Act
(Comprehensive Benefits
Package) |
| 7. Gebhardt/House Leadership |
| 8. Managed Competition Act
(Limited Benefits Package) |
| 9. Senate Finance Committee |
| 10. Bipartisan Health Care
Reform Act |

Table 3. Health Care Reform
Proposals, 1993-1994.

1. Clinton's Plan

President Clinton's Health Security Act was "a comprehensive proposal to provide a universal entitlement to health insurance for a broad range of services and to slow the growth of spending for health care." (CBO, February 1994, p. xi) It was founded on six fundamental principles: security, simplicity, savings, choice, quality, and responsibility. (President's Report, 1993, p. 17)

a. Security

The heart of the President's plan was guaranteed comprehensive health benefits to all Americans, including preventive care and prescription drugs. This concept, known as Universal Coverage, became the President's line drawn in the sand. Any health care legislation sent to him by Congress without universal coverage was considered unacceptable.

The basis of this tenet was the rising number of Americans without health insurance, or inadequate health insurance. In 1992, more than 37 million Americans had no health insurance, including 9.5 million children. Yet 85 percent of this group belong to families with at least one working adult (Figure 6). Millions more had inadequate coverage such that a serious illness would devastate family savings and security.

The Administration believed that the health insurance industry was part of the problem. The insurance practice of risk selection and underwriting is the core of

the problem. Insurance companies typically use health status to separate consumers into health risk categories. These categories are the basis for setting premium rates or denying coverage. (President's Report, 1993, p. 3)

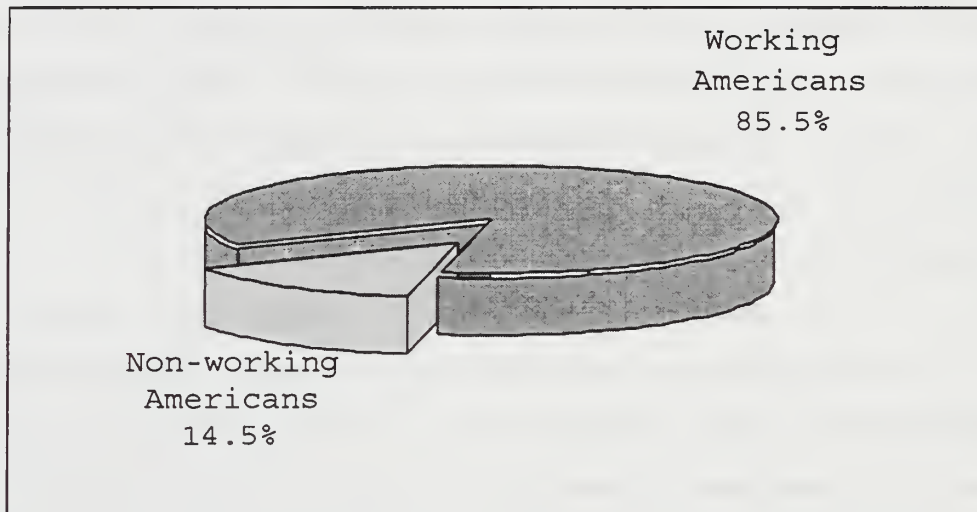


Figure 6. Who Are the Uninsured ? "From (President's Report, 1993, p. 3)."

b. Simplicity

The Clinton plan streamlined administrative paperwork by requiring all health plans to adopt a standard claim form, and establish a comprehensive benefits package. This would alleviate the growing administrative costs facing many small businesses, clinics, hospitals and doctors' offices. Administrative cost is one reason why many small businesses do not have health insurance. (President's Report, 1993, p. 6)

c. Savings

The Health Security Act affected savings and controlled health care costs by forcing the various health plans to compete against each other for health alliance

business. Competition was based on price and quality for a standard benefits package. Additionally, the plan limited the rate of growth of insurance premiums to ensure that costs did not spiral out of control.

Higher health care costs add to the price of goods and services supplied by American companies and put them at a real disadvantage in the international market place. For example, health costs add about \$1,100 to the price of every car produced in the U.S., about twice as much as in Japan. The U.S. spends far more than any of its foreign competitors on health care costs, with far less to show for it (i.e., the percent of the population without health insurance is fourteen times greater than the nearest competitor).

(President's Report, 1993, pp. 8-10)

d. Quality

The Health Security Act put patient care back into the hands of the doctors and hospitals, but armed consumers with health plan quality statistics. This forced health plans to compete on quality to attract new patients. The plan also emphasized preventive health care vice treating patients after they get sick. (President's Report, 1993, p. 19)

e. Choice

The Health Security Act provided choice, allowing consumers to pick from at least three health plans, no matter where they worked. Additionally, the plan allowed consumers to remain with their doctor of choice, or change health plans if not satisfied.

f. Responsibility

Responsibility addressed the need for drug companies, doctors, consumers, and employers to control prices and discourage frivolous medical malpractice lawsuits. It also required employers and employees to pay their fair share for health coverage. (President's Report, 1993, p. 20)

The bottom line is simple: every American pays when a company or individual fails to assume responsibility for health coverage or when insurance companies price people out of the market. Those who pay for health coverage end up paying for those who can not or do not. Restoring responsibility is vital to providing health security for every American. (President's Report, 1993, p. 15)

2. Gibbons Bill

This health care plan, approved by the House Ways and Means Committee, was built on a proposal by Representative Pete Stark (D-California). The bill preserved the key goal of the President's plan, providing health insurance for all Americans.

Employers were responsible for 80 percent of the family health insurance costs of their full time employees. Employers with fewer than 50 employees would receive tax credits, based on the number of employees, to reduce the cost of insurance premiums. Individuals were required to pay the costs not covered by their employers. Self-employed individuals could deduct 80 percent of their health insurance costs, beginning in 1998. (Cloud, 1994, p. 1797)

All health plans were required to offer a set benefits plan, established by Congress. This package included everything covered by Medicare, as well as "coverage for prescription drugs, pregnancy related services, chiropractic care, mental health and substance abuse treatment." (Cloud, 1994, p. 1797)

The bill established Medicare Part C to provide health care for the poor currently on Medicaid, the uninsured, and many employees of small businesses. Additionally, the Gibbons bill required insurers to cover and renew all eligible individuals or groups, without exclusions for pre-existing conditions.

It also established a system of cost controls to limit health insurance cost growth to the annual growth in GDP. The cost controls limited insurance reimbursement to Medicare payment rates in states which failed to limit growth of health care spending. (Cloud, 1994, p. 1797)

Insurers could operate in any of five markets: individuals, companies with between two and one hundred employees, large employers, associations' plans, and health alliances. In individual and small company market plans, community-ratings were suggested to hold down the cost of insurance premiums to the average costs for all people in a particular area. The bill did not require doctors and health care providers to join a health care plan. "Health plans would be required to allow enrollees to receive

treatment and reimbursement from providers outside the plan, as long as the individuals paid a higher portion of the cost." (Cloud, 1994, p. 1797)

3. Mitchell Plan

The health care bill unveiled by Senate Majority Leader George J. Mitchell (D-Maine) did not extend affordable insurance to all Americans. Instead, this bill aimed to cover 95 percent of Americans by the year 2000. This placated conservative Democrats, allowing market forces to increase coverage before requiring government enforcement. The bill did not require an employer mandate until 2002, and even then only targeted a limited group of businesses. Employers with 25 or more employees were required to pay 50 percent of the cost of their workers' premium. Employers with less than 25 employees were not required to participate. The bill provided subsidies for low-income people to help cover the costs of health insurance. (Rubin, 1994, p. 2205)

"This is a shift in the role of the so-called employer mandate from chief financing mechanism - its function in President Clinton's proposal - to enforcement tool." (Rubin, 1994, p. 2205) This role shift increased the financial burden on the consumer and all but ensured the measure would not attain 95 percent coverage by 2000. (Rubin, 1994, p. 2205)

The bill controlled costs by imposing a 25 percent tax on the amount a plan's premiums exceeded a target rate. The growth rate of Medicare costs were reduced and it capped the

annual amount the government could spend on all health care programs, including Medicare and Medicaid. Individuals or groups were encouraged but not required to form health alliances to purchase insurance. If no alliance existed in an area, the federal government would establish one. All insurance companies were required to practice community-rating. (Rubin, 1994, p. 2205)

4. Michel Plan

This plan used market forces to increase individuals' access to health insurance. It provided subsidies for low-income children, and possibly pregnant women and other low income individuals. Health insurance premiums were fully tax deductible after 1998 for self employed individuals and individuals not eligible to participate in an employer's health plan. It also provided tax incentives for medical savings accounts. (CBO, August 1994, p. 1)

The majority of employers were required to offer, but not contribute toward, health insurance for their eligible employees. Insurance companies were limited in their ability to deny coverage based on pre-existing medical conditions, and prohibited from denying renewal of coverage based on an individual's health status. Insurance premiums "could not vary within each type of plan except by age group, geographic area, or family size." (CBO, August 1994, p. 2)

This plan would have covered an additional two percent of the population with health care insurance, primarily through subsidies for low-income children. (CBO, August 1994, p. 1)

5. Managed Competition Act

This health reform measure sought to slow health care cost growth and expand health care insurance. It restructured the health care markets, provided incentives for purchasing health insurance, and subsidized health insurance costs for low-income individuals. (CBO, April 1994, p. ix)

The proposal encouraged people to purchase health insurance, but did not establish universal coverage. Employers were required to offer health plans to their employees, but were not required to pay for them. "Even without individual or employer mandates, the number of uninsured people would drop significantly under the proposal." (CBO, April 1994, p. ix)

The vehicle for health care market reorganization was regional health plan purchasing cooperatives (HHPCs). Individuals and employees of small businesses (generally fewer than 100 employees) could purchase a standard benefits package from accountable health plans (AHPs) through the HHPC. Strict requirements on AHPs would ensure open enrollment, limits on pre-existing condition exclusions, and a modified community-rating system. Premiums could vary only by age and enrollment type (i.e., individual, individual and spouse, individual and child, and individual and family). (CBO, April 1994, p. ix)

Firms with greater than 100 employees also had to offer their employees the opportunity to purchase health insurance

from AHPs. However, these firms, because of their size were not allowed to participate in HHPCs. (CBO, April 1994, p. ix)

Proposed tax code changes encouraged individuals to purchase health insurance, while discouraging overly generous policies. Health insurance premiums would be tax deductible up to a "reference premium" (i.e., the premium for the lowest-cost plan offered through the HHPC). Employers and employees were encouraged to select lower-cost health plans by limiting the allowable tax deduction. (CBO, April 1994, p. ix)

Under this plan, Medicare remained essentially unchanged. However, the Medicaid program was replaced by a system of federal subsidies to enable low-income people to purchase acute coverage from AHPs.

6. Gebhardt's Health Proposal

Gebhardt's proposal assured universal health insurance coverage offering a specified benefits package. People not currently eligible for Medicare were required to enroll in a private health plan or a new federal program (Medicare Part C). Employers were required to offer health insurance plans to their employees and pay 80 percent of the premiums. Individuals were required to pay any health insurance premiums not covered by their employer. Federal subsidies were proposed for low-income individuals. (CBO, December 1994, p. 1)

All employers were required to offer at least two types of health insurance plans: one with an unlimited choice of

doctors and the other a managed-care plan limiting the choice of doctors and the patients' ability to request specialists and have tests (Rubin, 1994, p. 2143).

Businesses with fewer than 100 employees had the option of enrolling in a private insurance plan or the federal Medicare Part C. Medicare Part C replaced the current Medicaid program for acute care services.

Health insurance plans were prohibited from pricing insurance based on pre-existing conditions. All plans sold to companies employing fewer than 100 employees were required to use a community rating system. (Rubin, 1994, p. 2143)

7. Senate Finance Committee

The plan crafted by a group of six moderate lawmakers, led by Senator Chafee (R-Rhode Island), relied on marketplace competition and insurance practice changes to provide affordable health insurance to 95 percent of Americans by the year 2002. The plan's enforcement mechanism was a "soft trigger"--Congress and the President would be allowed, but not required, to take action. (Rubin, 1994, p. 1707)

The plan restructured the health insurance market to control costs and improve access to insurance. Consumers and small businesses could form health insurance purchasing groups to buy standard benefits insurance package in a community-rated market. Larger businesses, generally employing more than 100 workers, could purchase health insurance based on an experience-rated market. To contain

costs, the proposal penalized high-cost insurance plans by imposing higher taxes. Subsidies were available for low-income individuals to help defray health insurance costs and wean them from Medicaid. (CBO, July 1994, pp. 1-4)

"The proposal would add about 20 million people to the insurance rolls, and the number of uninsured would drop to 8 percent of the population." (CBO, July 1994, p. 1)

8. Bipartisan Health Care Reform Act

This proposal sought to increase access to health insurance through marketplace reform and financial incentives for individuals to purchase insurance. Employers were required to offer health plans, but not to pay for them. The employer was required to offer at least two standardized plans: one which did not limit choice of doctors or health care providers, and one high-deductible (catastrophic) plan. The federal government subsidized health insurance for low-income individuals and people receiving Medicaid, provided they did not receive Medicare or Supplemental Security Income (SSI). The proposal made health insurance premiums fully deductible for self-employed individuals and partly deductible for individuals whose employer did not pay for health insurance. (CBO, October 1994, p. 1)

The proposal encouraged, but did not require, states to establish health plan purchasing organizations (HPPOs). HPPOs market health insurance to consumers and small businesses in a community-rated market. Larger businesses,

generally employing more than 100 workers, purchased health insurance from an experience-rated market. (CBO, October 1994, pp. 2-3)

The proposal also created tax benefits for medical savings accounts (MSAs) and long-term care insurance. Generally, individuals who enrolled in catastrophic plans were able to establish an MSA. However, welfare or SSI recipients, and individuals whose income is less than the federal poverty level, were ineligible for MSAs. (CBO, October 1994, p. 5)

D. HEALTH CARE BILLS AND THE DEFICIT

CBO scored a total of nine health care bills from the 103rd Congress, eight from 1994 and one--a single payer bill--in 1993. However, CBO did not compute the deficit implications for the single payer bill as part of its analysis. Therefore, that plan is not included in this discussion. Two bills (the Bipartisan Health Care Reform Act and the Gebhardt bill) are included despite the fact that CBO did not score them until after Congress had adjourned.

Of the eight bills considered, (see Figure 7) six would have decreased the cumulative deficit over the ten year period considered by CBO; two bills--the President's bill and the Gibbons bill--would have increased the cumulative deficit. However, the two bills increasing the deficit would have had a relatively small deficit impact.

The bills which reduced the deficit offered a wide range of impacts. The Mitchell option which excluded an employer mandate would have produced a negligible \$9.5 billion decrease in the deficit over ten years. The Bipartisan Health Care Reform Act would reduce total cumulative deficits by \$400.5 billion, a drop of more than 15 percent.

Of the eight bills CBO scored in 1994, only two were reported out of committee. The Gibbons bill was approved by the House Ways and Means Committee on June 30, 1994 by a 20 to 18 vote; two days later the Senate Finance Committee approved its bill by a 12 to 8 margin. Although not a product of any congressional committee, the Mitchell bill was the only health care measure considered by one of the full houses of Congress in 1994. Debate on the Mitchell bill took place during the second week of August, but it was pulled from the floor before any votes were taken.

None of the five remaining bills scored by CBO in 1994 received even this limited congressional endorsement. No congressional committee adopted the Administration's plan. No committee acted on the Michel bill, the Bipartisan Health Care Reform Act or the Managed Competition Act, although portions of the latter were incorporated in the Senate Finance Committee bill.

The deficit implications of these health care bills does not appear immediately or directly responsible for their limited support. The deficit impact had more of an indirect effect. In an effort to reduce the deficit, most

of the health care reform bills included stiff provisions for containing costs and increasing revenues. Such measures probably more than offset support for provisions that increased coverage and introduced other desired changes to the status quo.

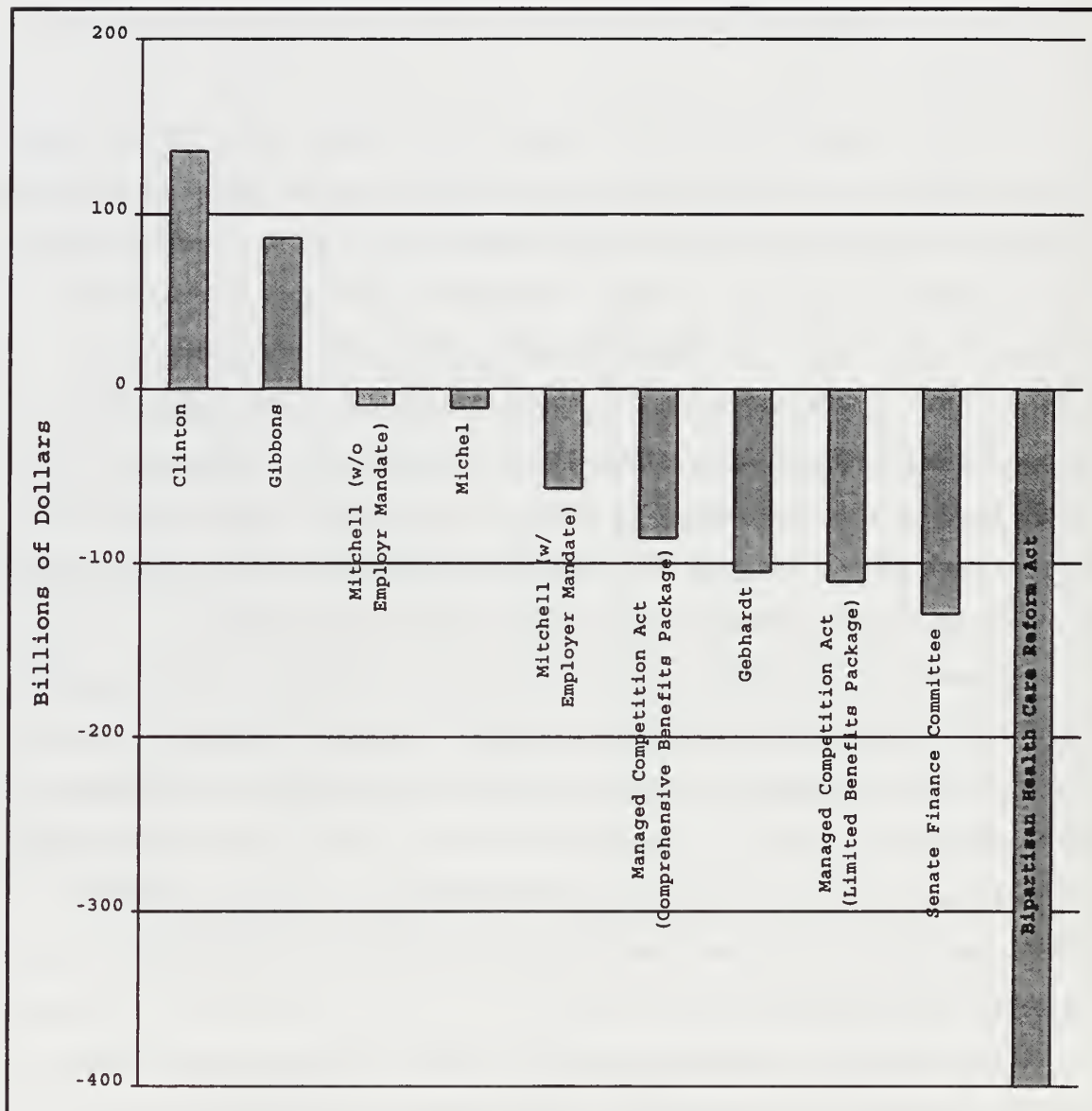


Figure 7. Deficit Estimates of Health Care Reform Proposals, 1993-1994. Source: Congressional Budget Office.

E. CONCLUSIONS

CBO's verdict that health care programs are fueling future growth in federal deficits was reinforced during the 103rd Congress by the Bipartisan Commission on Entitlement and Tax Reform. The Commission, a political byproduct of President Clinton's deficit reduction budget proposal for Fiscal Year 1994, reviewed the budget implications of entitlement spending and tax expenditures. Meeting in 1994, the second year of the health care reform debate, the 32 member panel implicated entitlements, especially health care, in "the tidal wave of debt built into the future" (Shear, 1994, p. 1682).

Noting that the deficit outlook worsens at the end of the decade, the Commission emphasized the imbalance between "the government's entitlement promises and the funds it has available to pay for them" (Bipartisan Commission on Entitlement and Tax Reform, 1994). The Commission highlighted the findings of the Medicare Trustees, who reported that the Hospital Insurance Trust Fund (which pays a portion of Medicare Part A) "is severely out of balance and is unsustainable in its present form. . . The Trust Fund is projected to run out of money by 2001" (Bipartisan Commission on Entitlement and Tax Reform, 1994). The Co-chairman of the Commission, Senator Bob Kerrey, expressed his hope that these findings would increase support for

health care reform, "serving as a reality check on the cost of any expanded health entitlements" (Hagar, 1994, p. 1584)

The demise of health care reform during the 103rd Congress had less to do with the deficit than with the politics behind the reform process. President Clinton submitted an in depth and detailed (1342 pages) reform package. Furthermore, he declared at the beginning of the debate that universal coverage would be the line drawn in the sand. He provided Congress little opportunity to refine health care policy to garner the support needed to pass both houses of Congress. Additionally, the Administration's decision to forego a bipartisan approach to health care reform set the tone for setbacks and the political fiasco which ensued. Republicans, who were not seriously included in the reform debate, used parliamentary maneuvers to block or delay action. Even more damaging to health reform was the time it took for the Administration to transmit its proposal to Congress. Conceptualized during the Presidential elections in 1992, the plan was not presented to Congress until the end of October 1993. This only left congressional leaders one year to craft reform legislation which the President would find suitable. Reform ultimately fell victim to time pressures at the end of the legislative session.

In addition, insured Americans seem to have difficulty empathizing with the uninsured. Sacrifices are required of the insured to reform the nation's health care system. When the vast majority of the insured are satisfied with the

status quo there was no clear mandate to change the system. Without this mandate, it was relatively easy for those opposed to major change to block reform. In the end, there was no political constituency strong or committed enough to steer the reform legislation through the many bumps and detours on the road to congressional passage and presidential signature.

According to the *Wall Street Journal*, the fact that health care reform was not enacted during the 103rd Congress was nothing less than a "seismic event," representing the "demise of entitlement politics" (Stein, 1994, p. A14). Uwe Reinhardt was more modest in his judgment, concluding only that "America is an incremental country and health care too has to be done incrementally" (Rubin, 1994, p. 2344).

The difficulty of and necessity for estimating the budget consequences of health care reform will not disappear. Health programs have become too strongly linked to budget deficit. They are the most rapidly growing entitlement programs, and entitlements are increasingly associated with uncontrolled spending and rising deficits. One economist noted that "...health spending is not the edge of the entitlement problem. It is the essence of the problem" (Samuelson, 1994, p. 5).

III. HEALTH CARE REFORM AND THE REPUBLICAN BUDGET REVOLUTION, 1995

After seizing control of Congress for the first time in 40 years the, the Republican-led majority quickly laid out their ambitious agenda, outlined in their "Contract with America". This agenda showcased the Republicans successful but seemingly contradictory campaign pledge to cut taxes but still balance the budget. The promise set the stage for new and often bitter public debates between the Republican-led Congress and President Clinton on reform of the government-financed health care system, principally Medicare and Medicaid. This campaign promise was made more difficult by Republican guarantees that the budget could be balanced and taxes cut while keeping Social Security, defense spending and interest on the federal debt off the table. Thus over half of what the federal government spends was pledged to be exempt from cuts. (see Figure 8).

A. FEDERAL DEFICIT OUTLOOK

After two years of declining deficits, and the fiscal year 1995 deficit expected to be the smallest since 1989, CBO was predicting the deficit to resume an upward trend in 1996. These predictions of increasing deficits (Figure 9) spurred the Republicans proposal to balance the federal budget by 2002.

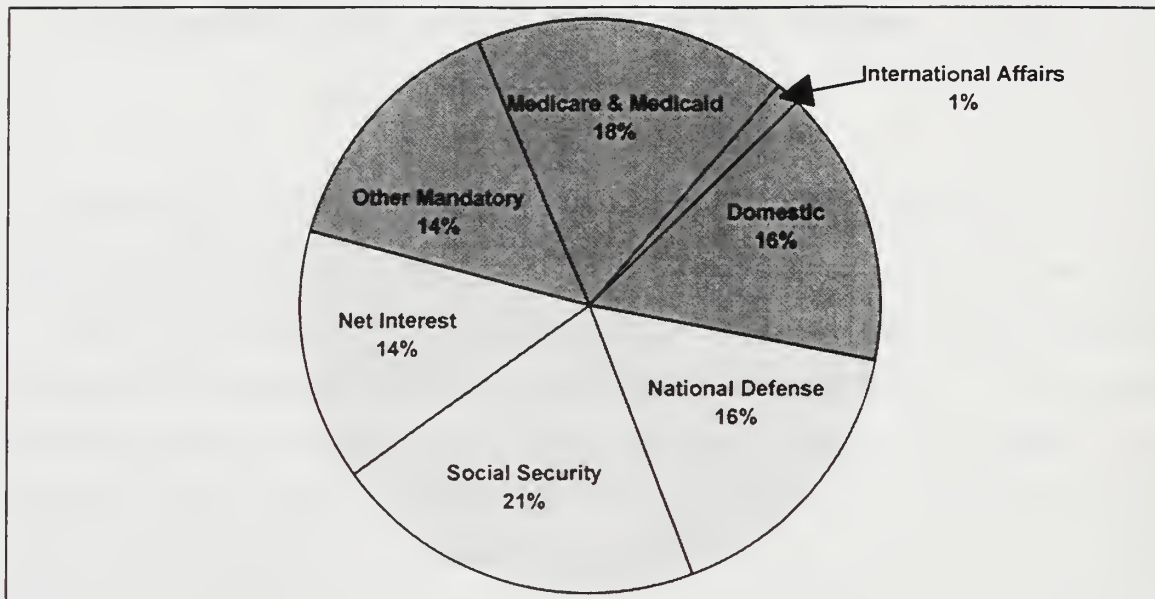


Figure 8. CBO Projected Baselines for FY 1996.
Source: CBO, Aug 1995, p. 22.

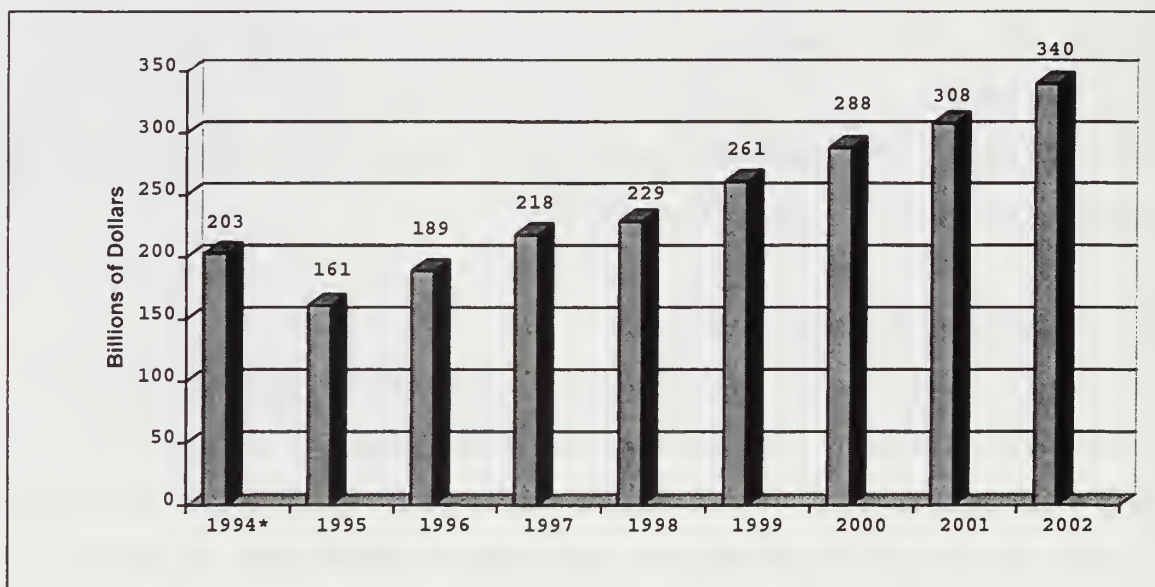


Figure 9. Deficit Predictions, by fiscal year (* is actual)
Source: CBO, Aug 1995, p. 22.

CBO's projections assumed that tax laws and mandatory spending remained unchanged, and that discretionary spending remained within the spending caps, imposed by the Budget Enforcement Act (BEA) of 1990, through 1998.

These projections continued to paint a grim picture for the Administration and the Congress. Federal revenues were expected to remain fairly constant as a percentage of GDP over the next decade, and most major spending programs were projected to grow no faster than the economy; however, the deficit was expected to spiral upwards. The deficit was being driven by the two major health care entitlements--Medicare and Medicaid--whose costs were continuing to explode.

Rising at an annual rate of about 10 percent, total Medicare and Medicaid outlays were expected to double by 2005. The rapid growth of Medicare explained why the Hospital Insurance Trust Fund (Medicare Part A) began running a deficit in fiscal year 1995; it was expected to be out of money in 2001. CBO estimated that combined Medicare and Medicaid spending would nearly equal total discretionary spending in ten years, or exceed it if discretionary spending were not allowed to keep pace with inflation. (CBO, Aug 1995, pp. 22-27)

1. Comparison with Administration's Projections

CBO and OMB agreed on the projected budget deficit for fiscal year 1995; however, CBO's deficit estimate for 2002 was \$124 billion dollars higher than OMB's estimate, and \$214 billion higher by 2005. Differences in economic

assumptions, along with other technical estimating differences, created large discrepancies between the two organizations' deficit estimates (Table 4). (CBO, Aug 1995, p. 27)

	95	96	97	98	99	00	01	02	03	04	05
OMB Baseline	160	185	197	194	202	208	206	216	222	235	248
CBO Baseline	161	189	218	229	261	288	308	340	375	414	462

Table 4. Comparison of CBO and OMB Midsession Review Budget Deficit Baselines Predictions, in billions of dollars.

Source: CBO, Aug 1995, p. 28.

On average, the Administration foresaw faster economic growth and lower inflation than did CBO. Because inflation, as measured by the Consumer Price Index (CPI), affects indexed benefits and tax brackets, and GDP affects estimates of taxable income, CBO's assumptions resulted in a larger gap between the two growth rates. Lower inflation translated to a smaller rate of growth of indexed benefits and smaller tax bracket offsets. Faster economic growth resulted in a larger tax base for federal revenues. The end result of the differences between CBO and OMB was CBO's lower expected revenues and higher growth rates for indexed benefits. This resulted in larger projected deficits and a less rosy economic outlook. (CBO, Aug 1995, pp. 27-28)

B. THE BUDGET PROCESS

The annual ritual of crafting a budget for the federal government has its modern origins from the Congressional Budget and Impoundment Control Act of 1974. This act established the House and Senate Budget Committees, the Congressional Budget Office (CBO) and the basic legislative tools used in the budget process.

1. Budget Resolution

The first step in the budget process is congressional fashioning and adoption of a budget resolution. This strictly congressional document sets targets for new budget authority, outlays, revenues, deficits or surpluses and the total federal debt. The document is eventually adopted as the concurrent resolution after identical versions are passed by both houses of Congress. However, since the concurrent resolution never goes to the President for his signature, it does not have the force of law. Its passage imposes restrictions on Congress (e.g., in the Senate, strict time limits on debate for budget resolutions prevent a filibuster).

The concurrent resolution establishes strict spending targets for the government as a whole. The totals in the concurrent resolution are used to derive the maximum amount of money that can be appropriated for a given fiscal year. Additionally, since 1990 the concurrent resolution has been used to establish spending totals for defense and non-

defense discretionary appropriations, under spending caps originally implemented by the 1990 Budget Enforcement Act (BEA).

2. Reconciliation

The reconciliation process was originally designed to implement the spending and tax policy decisions in the concurrent budget resolution. However, it has since come to focus upon a single category of federal spending: entitlements.

Reconciliation enables Congress to equally consider all spending, as well as taxes, as a means of achieving deficit reduction. The larger the share of deficit reduction assigned to entitlement cuts and tax increases by the concurrent budget resolution, in relation to discretionary spending cuts, the more important reconciliation becomes.

Changes made to entitlement programs and tax laws by the cognizant House and Senate Committees are wrapped up into an omnibus budget reconciliation bill. This bill is sent to the House and Senate floors, where it is handled under special rules.

Typically, the arduous job of passing a reconciliation bill has kept Congress in session well after its expected adjournment date. Between 1990 and 1996, Congress successfully used the reconciliation process three times. Twice, in 1990 and 1993, Congress adopted enormous multi-year packages of tax and spending measures, used to reshape the fiscal landscape.

In 1990, with deficits soaring, Congress and the President crafted a five year deficit reduction plan. The cornerstone of the plan was the reconciliation bill which promised to cut the deficit by \$482 billion over five years. The bill provided for deficit reduction by relying on savings and tax increases, and included a five year budget process. This budget process included caps on discretionary spending and pay-as-you-go rules for taxes and entitlements. (Cranford, 1995, p. 2715)

In 1993, deficit fever was again rampant in Congress. Democratic leaders in Congress advised the President that the first order of business was a serious deficit reduction package. The President and Congress pushed through a \$433 billion dollar deficit reduction package, relying nearly half and half on spending reductions and new taxes. This package, because of the new taxes, did not garner a single Republican vote, twice requiring the Vice President to break tie votes in the Senate. The final reconciliation bill continued most of the rules pioneered in the 1990 reconciliation bill, and extended the discretionary spending caps through 1998. (Cranford, 1995, p. 2715)

C. FY 1996 BUDGET

In the 1990 budget deal, then President Bush brokered a deficit reduction package. It relied heavily on defense cuts and tax increases, while allowing for increased non-defense spending and unlimited growth in entitlement spending. By 1995, the politically volatile health

entitlements had ballooned to growth rates of 10 percent or more per year, while spending for some domestic programs had increased two to three times the rate of inflation. (Hager, 1995, p. 1365)

The fiscal year 1996 Republican budget would stop all this. The Republican budget promised to balance the budget in seven years, both by controlling the growth of two of the largest entitlement programs, Medicare and Medicaid, and by sharply reducing the size of the federal government. This budget proposal was all the more unique in that it proposed to do all this while at the same time providing for a huge tax reduction package for the American people.

1. The Republican Budget Proposal

The Republican's plan would use the reconciliation process, not as a minor adjustment in tax and spending policy, but as an aggregate tax and spending measure designed to revamp federal spending for years to come. In a clearly partisan fashion, the Republican-controlled Congress voted on June 29, 1995 for a seven-year GOP blueprint to balance the budget (see Table 5). The budget resolution locked the Congress into a process requiring committees to produce \$894 billion in spending cuts by 2002.

	1996	1997	1998	1999	2000	2001	2002
House	-156	-176	-140	-134	-108	-61	0.5
Senate	-157	-128	-98	-86	-74	-30	1.3
Final Conference	-170	-152	-116	-100	-81	-33	6.4
CBO Baseline	-189	-218	-229	-261	-288	-308	-340

Table 5. Deficit/Surplus Dollars in Billions Projected by the Conference Report in the Fiscal Year 1996 Budget Resolution. Source: Fiscal 1996 Budget Resolution (H Con Res 67 - H Rept 104-159) and CBO August 1995.

The Republicans' huge deficit reduction package was not much larger than the 1990 and 1993 deficit reduction packages, when measured in 1995 constant dollars. The Republican package called for \$894 billion in deficit reduction over seven years, but would only realize \$537 billion in the first five years. Compare that with the deficit reduction package backed by President Bush in 1990 (\$560 billion in 1995 dollars) and President Clinton's 1993 deficit reduction plan (\$459 billion in 1995 dollars). (Hager, 1995, p. 1299)

The difference was how the various packages realized deficit reduction. Both the 1990 and 1993 packages relied heavily on tax increases and defense cuts. The Republican plan relied on slowing the growth of entitlements and non-defense cuts, while providing for tax reductions and modest defense increases. (Hager, 1995, p. 1299)

a. Medicare

The budget resolution committed the Republicans to reducing Medicare by \$270 billion over a seven year period. How the reductions were to be carried out was not clear. There were differences between the House and Senate versions, and even within the respective chambers, on how to meet the Medicare budget resolution goals.

In their quest to hold down the growth of Medicare, the Republicans looked at various proposals designed to set a flat federal fee for health care and replace the open ended guarantee of coverage. The current system required the government to pay for all qualified expenses. However, by changing Medicare to a defined contribution or voucher system, Congress would give itself the ability to control costs. In a defined contribution system, Congress would provide recipients a predetermined payment or voucher, to help defray their costs of a private insurance policy. Payments would be adjusted for age, sex, geographic location and institutional status, which means some beneficiaries would receive higher payments than others. "Only by eventually moving all seniors to privately managed systems operating under a defined federal contribution could the federal government truly restrain cost growth and drive efficiency into the system," said Thomas A. Scully, president of the Federation of American Health Systems. (Fraley, 1995, pp. 2189-2190) Proponents of the defined federal contribution approach argued that giving seniors choices encouraged them to shop around for the

health package which would meet their needs. This would encourage competition. These were themes reminiscent of the President's health care reform package in 1993. (Fraley, 1995, pp. 2189-2190)

Other alternatives for slowing Medicare growth were block grants, higher co-payments and deductibles, reduced payments to providers, and new formulas for spending federal dollars.

Republicans were clearly aware of the dangers they faced in attempting to change a very popular social benefit for the elderly. However, they were convinced that if they could produce a program that actually balanced the budget, without draconian cuts in Medicare, and simultaneously provided a tax cut, they furthered their chances of maintaining power in Washington. According to House Speaker Newt Gingrich (R-Ga.), in a June 28 interview with the Atlanta Constitution, "If we solve Medicare, I think we will govern for a generation" (Fraley, 1995, p. 1900).

However, Republicans were very sensitive to Democratic attacks in the press. For example, House Minority Leader Richard Gephardt (D-Mo.) charged that "these cuts will devastate seniors for decades" (Fraley, 1995, p. 1900). Republicans contended that they were not cutting Medicare, just controlling its growth from budget busting levels of 10 percent per year to about 6 percent (see Figure 10). They also pointed to a report from the Medicare Board

of Trustees warning that the Hospital Insurance trust fund (Medicare Part A) would be broke by 2002 if changes were not made. (Fraley, 1995, p. 1900)

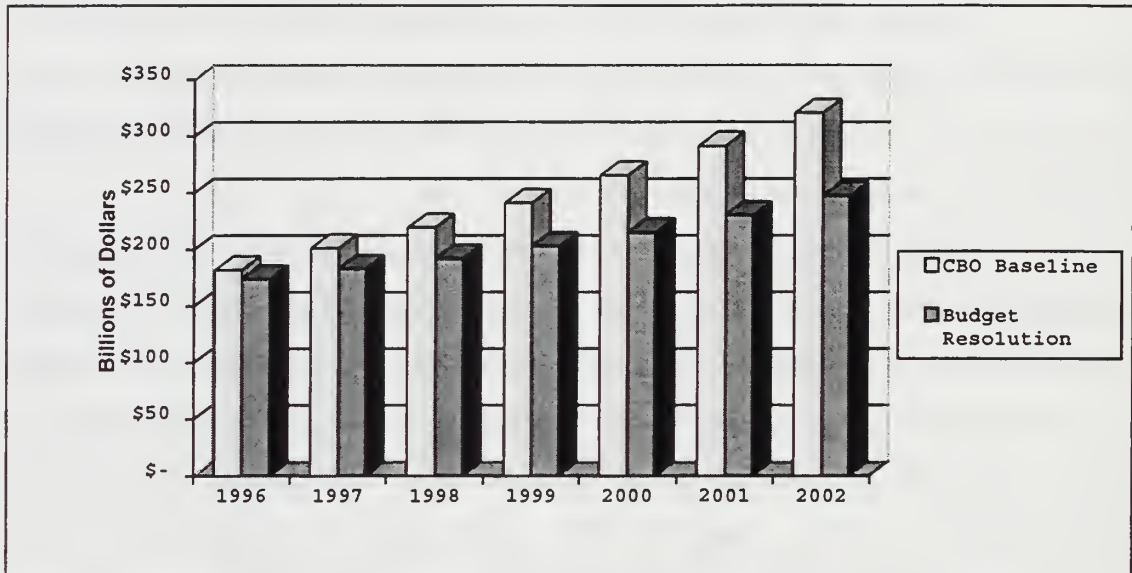


Figure 10. Medicare Growth Under Budget Resolution.
Source: House Budget Committee.

The conference agreement on the deficit reduction budget reconciliation measure (HR 2491 - H Rept 104-350), was finalized in November (one and a half months after the start of the new fiscal year). It laid out the Republicans' plan to overhaul Medicare (Figure 11). The plan emphasized market forces and encouraged seniors to move to managed care institutions, including Health Maintenance Organizations (HMOs). Medicare beneficiaries would be allowed to keep the current Medicare system, but would have additional options. They could opt for joining a managed care institution, buying a high deductible insurance policy combined with a

medical savings account (MSA), using a network of providers, or joining union or association health plans.

The monthly premium for Medicare Part B, which was scheduled to drop from 31.5 percent of the program's costs to 25 percent in 1996, would remain at 31.5 percent for the seven year period. Means testing would become part of the Medicare Part B payment system. Single beneficiaries earning \$60,000 in annual incomes and couples earning \$90,000 in income would face higher costs. The costs would gradually increase until the subsidy ended at \$110,000 for singles and \$150,000 for couples. (Fraley, 1995, p. 3536)

Changes in the payment system to hospitals and providers would modify the reimbursement amounts for inpatient and outpatient hospital costs. This would reduce the amount of money spent on capital costs for hospitals and nursing homes. Additionally, payment reductions would be made to all hospitals that served a higher percentage of indigent patients, on a shifting scale, from 5 percent to 30 percent, over the seven year period. Skilled nursing facilities would transition to a prospective payment system from the current method of paying the facilities on a "reasonable cost" basis. Under a prospective payment system, payments for health care services would be at a fixed rate based on a prenegotiated amount. Thus nursing facilities would face a negotiated fee structure vice the more open ended reasonable cost basis. (Fraley, 1995, pp. 3536-3537)

The Republican plan called for a fail-safe enforcement mechanism. If budget targets were not met, then the fail-safe mechanism would automatically cut payments to providers in the traditional Medicare program, commencing in 1998.

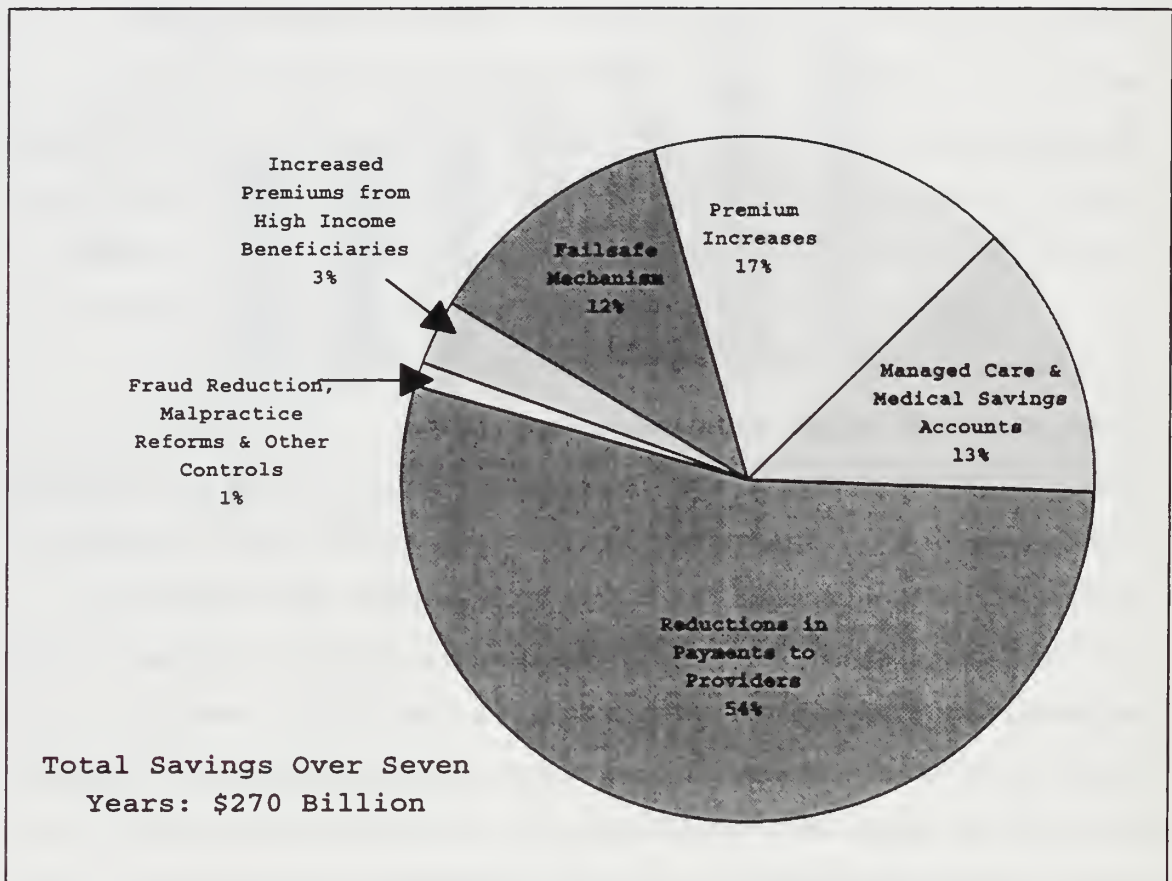


Figure 11. Distribution of Medicare Savings in the Republican Reconciliation Bill.

Source: "Healthcare," Standard & Poor's Industry Surveys, Jan 11, 1996.

b. Medicaid

The budget resolution looked for \$182 billion in Medicaid spending reductions over a seven year period. This

was considered to be politically less risky than the Medicare reduction, mainly because of the public's perception about whom the program helped. Public perception links Medicaid to welfare, i.e., it is a program for the poor.

The proposals considered to reduce the federal government's Medicaid costs included capping spending growth at a rate substantially less than 10 percent and turning the program into state block grants, with fewer federal restrictions or mandates. State governors, in general, supported block grants and more control over coverage and services offered. States argue that they are in a better position to understand and address the needs of their residents. According to Dr. Michael D. McKinney, Director of Health and Human Services in Texas, "we are looking for minimal restrictions, except to go forth and do good" (Fraley, 1995, p. 1639).

The conference agreement on the budget reconciliation measure (HR 2491 - H Rept 104-350) finalized the Republicans' plan to overhaul Medicaid. The agreement scaled back the required savings target from \$182 billion to \$163.4 billion over seven years. The central elements of the plan were to turn the program over to the states, in the form of block grants, and give them far more flexibility in deciding whom to cover and at what level. However, language in the report would require states to provide some form of support for pregnant women and children under the age of 13. (Fraley, 1995 p. 3539)

Negotiators agreed to distribute the federal pool of dollars, one of the most contentious aspects of the plan, on a needs based formula. This formula would take into account the number of poor residents in a state, the state health care cost index, and the state's case load. Every state would have been guaranteed minimum growth rates in federal dollars, ranging from 3.5 percent in 1997 to 2.5 percent in 1999 and 2 percent subsequently. The maximum growth rate would have been 9 percent in 1997 and 5.33 percent in later years. (Fraley, 1995, p. 3540)

2. President's Budget Proposal

Compared to the Republican's proposals for a \$200 billion five year tax cut and balancing the budget in seven years, President Clinton's budget proposal was decidedly modest. In his budget, submitted February 6th, the President proposed middle class tax cuts of \$63 billion over five years. These tax cuts would be financed by \$144 billion in spending cuts, producing a net deficit reduction of \$81 billion. This deficit reduction was less than a fifth of what his 1993 budget package produced, and was not nearly enough to set the budget on a balanced path. (Hager, 1995, p. 403)

In fact, the President's budget was little more than a mere legal formality (Figure 12). Missing from the President's budget were the details and attachments normally associated with the executive branch's budget submission. The President was cautious after the demonization of his 1993 deficit reduction plan and the derailing of his 1994

health care reform proposals. He sent a clear message to the new congressional leadership: it is now your turn to take the ball and run with it. In a shot at the new congressional leadership, President Clinton said, "anyone can offer a tax cut or propose investment. The hard part, of course, is paying for them." (Hager, 1995, p. 403)

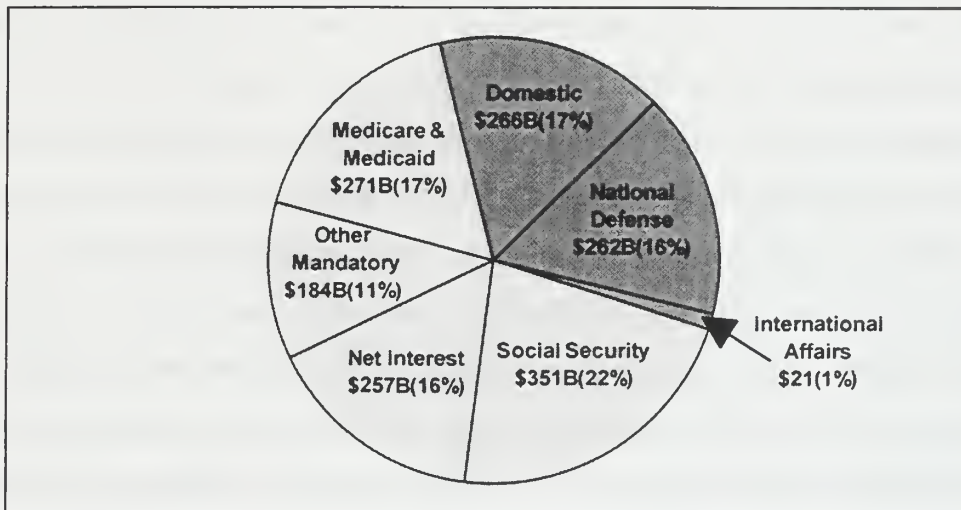


Figure 12. President Clinton's Proposed Budget, February 1995, in billions of dollars. "From (Hager, 1995, p. 404)"

The President's budget called for \$1.6 trillion in spending for 1996, up 4.8 percent from 1995. Overall spending would increase at an annual rate of 4.3 percent, driven mainly by entitlement programs (growing at an annual rate of 6.7 percent) and interest on the national debt (growing at an annual rate of 4.8 percent). In contrast, domestic spending would decrease over the same period of time, and defense spending would grow slightly, although less than the inflation rate. (Hager, 1995, p. 404)

The net effect of the President's budget was to continue the trend of entitlement growth. Projections showed that by 2000, entitlements would absorb about 55 percent of the budget, while discretionary appropriations would shrink from 34 percent to 29 percent of the budget. (Hager, 1995, p. 404)

On June 13th, President Clinton, in a brief, nationally televised address, quickly shifted gears after the House and Senate approved the budget resolution mandating a seven year deficit reduction plan. Declaring, "it is time to clean up this mess, (Hager, 1995, p. 1715)" the President agreed for the first time in principle to work toward a balanced budget. After months of verbal sparring and demonizing the Republicans' plan to balance the budget, the President unveiled his proposal to balance the federal budget by the year 2005, three years later than the Republican proposal. The President had transformed the budget debate from a partisan argument about the wisdom of balancing the budget to a debate on how to do it, and how fast.

The Republicans, for their part, happily embraced the President's implicit approval of their fundamental goals - to reduce the size of government, balance the budget, cut taxes and sharply reduce spending on Medicare and Medicaid. However, they were more than a bit skeptical of the numbers used in the President's budget and its substance. (Hager, 1995, p. 1715)

The President's budget marked a tremendous--and to some Democrats, acutely embarrassing--shift of policy. The

Democrats, including the President, had repeatedly claimed that the Republican agenda which mixed a tax cut with a balanced budget was impossible and unwise. The President's budget largely shadowed the Republican approach, with the notable difference in timing and scope. A major difference was that the President's plan would have preserved the signature initiatives of his administration, such as spending on education, the National Service program, health research and anti-crime programs. (Rubin, 1995, p. 1718)

The President's proposal provided for \$520 billion in deficit reduction over seven years and \$1.1 trillion over ten years, as scored by the more optimistic OMB. His proposal for a modest tax cut of \$105 billion over ten years was targeted at middle to low income families. These cuts were mainly focused on tax credits for children, college tuition deductions, and expanding tax-deferred contributions to Individual Retirement Accounts (IRAs).

The plan included modest savings in Medicare and Medicaid. Medicare savings were expected to total \$128 billion, of which 70 percent would fall on hospitals, and the balance on lower reimbursement rates for doctors. The President combined these Medicare cuts with a small, \$28.3 billion, expansion in health insurance coverage. Medicaid savings were expected to total \$54 billion. Savings were captured by capping the program's expenditures on a per capita basis; Medicare maintained its status as an entitlement program. Discretionary spending would be cut by \$200 billion, of which \$197 billion came from non-defense

programs. The cuts in most domestic spending programs averaged 20 percent, except for a handful of favored Administration programs. These programs actually saw slight increases. (Rubin, 1995, p. 1718)

The Republicans charged that the President's budget would not come close to balancing the budget, a charge supported by CBO analysis of the budget released June 16th. This analysis indicated that the President's budget left a deficit of \$209 billion in 2005, the year the President projected a balanced budget. (Hager, 1995, p. 1719)

3. Budget Summit

On December 6th, over two months into the new fiscal year, President Clinton vetoed the Republican reconciliation bill. This action was not much of a surprise. The President had indicated in June that provisions of the bill were unacceptable, chiefly those pertaining to Medicare and Medicaid savings. The President's veto initiated a series of budget summits between the White House and the Republican congressional leadership. These talks advanced the public notion that a budget agreement could be reached, and that the outcome would be a federal budget which placed the country on a glide path to a balanced budget. These views were reinforced by news that the President had agreed to balancing the budget in seven years, although the President stopped short of agreeing to use CBO figures.

On December 15th, budget talks collapsed under angry recriminations by both sides. The Republicans dismissed the newest White House offer as nothing more than book-cooking;

President Clinton accused the Republicans of demanding "unconscionable" cuts in health care programs for the poor and elderly, namely Medicaid and Medicare. The enraged Republicans indicated they would not approve another stopgap spending bill (a series of which had been funding the government since the beginning of the new fiscal year) until the President met their minimum condition for a budget compromise. This condition was balancing the budget in seven years using CBO projections. (Hager, 1995, 3789)

The two sides had been inching closer together when negotiations broke off although they were still miles apart. A CBO re-estimate of the Republican reconciliation bill, vetoed by the President, and the President's proposal submitted December 7th (Table 6), indicated that only the Republicans' budget achieved balance. The President's proposal left a deficit of \$115 billion, even after CBO gave the proposal credit for an economic dividend. CBO indicated this dividend would only occur if the budget was balanced.

Category	Republicans	Clinton	Difference
Discretionary	\$-408	\$-240	\$168
Medicare	\$-226	\$-97	\$129
Medicaid	\$-133	\$-37	\$96
Poverty Programs	\$-87	\$-41	\$46
Other Mandatory	\$-35	\$-4	\$31
Tax Cuts (Net)	\$218	\$81	\$-137
Debt Service	\$-80	\$-46	\$33
Total	\$-750	\$-385	\$365

Table 6. The Budget Gap, Budget Projections over Seven Years as Scored by CBO. "From (Hager, 1995, 3792)".

Partisan bickering continued with brief glimpses of light through the Christmas holiday. Prior to breaking for Christmas, the Republican-led Congress voted a continuing resolution (CR) to partially fund the government through January 3rd. The CR would fund the District of Columbia and provide for veterans and welfare benefits, while locking a quarter of a million federal employees out of work. (Hager, 1995, p. 3874)

On January 6th, after resisting for nearly a year, President Clinton agreed to the Republicans' minimum condition for a budget compromise--a plan to balance the budget in seven years as estimated by CBO. In return, Republicans sent him a CR to fully fund the government through January 26th. It finally appeared as if the two sides were serious about reaching a budget compromise. However, as hard as it was to get the two sides to this point, it appeared even harder to get them to agree on the policies that would produce the budget savings. This divide on policy issues was amplified by remarks from President Clinton.

If this is about balancing the budget we could do it in about 15 minutes tomorrow afternoon. The issue here is over policies involved in Medicare and Medicaid, our opposition to raising taxes on the lowest paid working people...if we are going to walk away from the fundamental commitment of Medicare we ought to have an election about that. (Rubin, 1996, p. 89)

The divide was also described by the Speaker of the House, on a January 10th visit to Wyoming.

I think the odds are better than even, as of today, that there will be no agreement, and I find that a very difficult prospect. It may just be that we need one more election; it may literally be that the Clinton administration cannot agree to the kind of decentralization and lower spending and lower taxes that we represent. (Rubin, 1996, p. 89)

4. Reconciliation Failure

Negotiations between the White House and Congress continued through March, with each side compromising a little. However, the policy issues dividing the two sides could not be overcome. Desperate to avoid a third partial shutdown of the federal government, both sides agreed to a stopgap bill that would fund the government through the April congressional recess. This, in effect, signaled the end of the Republicans' attempt to balance the budget in seven years, drastically reducing the size of government, and providing for a middle class income tax cut. In the end, the two sides had come tantalizingly close in numbers. Their split on Medicare had closed from \$129 billion to as little as \$30 billion over seven years. Their split on Medicaid had closed from almost \$100 billion to just \$26 billion over seven years. However, the narrowing differences were misleading, since they camouflaged deal-breaking policy disagreements. (Hager, 1996, pp. 149-150)

D. CONCLUSIONS

The conclusions by CBO that growth in federal expenditures for health care, principally Medicare and Medicaid, were fueling federal deficits led the Republican-controlled Congress to tackle these entitlement programs. In their Contract with America, the Republicans pledged to balance the federal budget, dramatically reduce the size and scope of the federal government, and reduce taxes for the American people. This promise was made against a backdrop in which the Republicans pledged that the budget could be balanced and taxes cut while keeping Social Security, interest on the debt, and defense spending off the table. Thus over half of federal expenditures were protected.

Budget proposals and debate in the 104th Congress were strictly partisan, with little regard for the priorities or policy views of the Democrats. The strictly partisan nature of the fiscal 1996 budget process underscores the lessons of the 1993-1994 health care reform debate. In the case of the FY1996 budget, congressional Democrats, who were not seriously considered in the budget process, used the media and public fear to force compromise with the Republican majority. The Republican leadership, believing their Contract with America provided them the public mandate to shape the direction of federal spending, launched a campaign designed to reshape the structure of the social safety net for the elderly and the poor. However, the process became entangled with the notion of tax cuts for the rich; it all but ignored saving the safety net for future generations.

Thus, the budget became easy prey for attacks by the Democratic leadership and the ultimate fears perceived by the public.

The failure of the fiscal year 1996 reconciliation bill to balance the budget and stave off the growth of federal health care programs will not end the issue. The federal role in financing health care will remain a political hot button for two reasons. First, public pressure to balance the budget will keep Medicare and Medicaid in the public spotlight. These two programs represented more than 22 percent of federal spending in 1996 (excluding interest on the debt); they are projected to grow to more than 27 percent of federal spending by the year 2002. (CBO, Aug 1996, p. 2) Additionally, the increase in spending on Medicare and Medicaid, as a percent of GDP, accounts for all the projected increase in the federal deficit between 1996 and 2002. (CBO, Aug 1996, p. 2) Second, the retirement of the baby boom generation, starting in 2010, portends large increases in federal spending for Medicare and Medicaid. For these two reasons, the problem associated with federal health care financing will not go away. (Aaron, 1996, p. 35)

The end result of the Republican budget was that the budget deal became entangled in positioning for the make-or-break 1996 presidential elections. The Republicans were hoping to consolidate their hold on Congress and win back the White House, while Democrats hoped to turn back the Republican revolution and win back control of the Congress.

Democrats and their allies hoped to paint the Republicans as Medicare's undertakers, while largely ignoring their own overhaul proposals. National advertising campaigns suggested that the Republicans wanted to savage the program, removing the health care safety net "earned" by the elderly. "We worked all our life, and then you get old enough to enjoy it a bit and it is taken away from you and you have nothing. I don't think it is fair," said Charlotte McChesney, 75. (Rich, 1995, p. 6) According to William Kristol, a conservative political strategist and editor of the Weekly Standard, "In a courageous but foolhardy way, Republicans touched the third rail" (Georges, 1996, p. A20)

IV. GOING THROUGH THE MOTIONS: HEALTH CARE REFORM IN 1995/96

Early in 1995, House Republicans, buoyed by their success and looking beyond their "Contract with America," turned their sights to an issue which had eluded President Clinton and the Democrats in 1994: health care reform. Five House Republicans, all chairmen of key committees or subcommittees, sponsored three bills to make health insurance easier to obtain and more affordable. The three bills were considerably more modest than the 1993-94 plans to revamp the health care system. The central aim of each bill was to expand health insurance coverage, making it more difficult for insurance companies to deny insurance to anyone, including small businesses and people who shift jobs or have pre-existing conditions. At the same time, the bills encouraged businesses to offer health insurance. These themes enjoyed bipartisan support during 1994. (MacPherson, 1995, p. 944)

A. FEDERAL DEFICIT OUTLOOK

After two years of declining deficits, and CBO estimating a third consecutive year, the outlook for the immediate future was much less optimistic. CBO projected that the deficit would rise from an estimated 1995 low of \$161 billion to \$340 billion by 2002. CBO projections spurred the Republican Congress to push for a balanced

budget constitutional amendment and a proposal to balance the federal budget by 2002. (CBO, Aug 1995, P. 22)

B. EARLY HEALTH CARE REFORM PROPOSALS IN THE HOUSE

The three health reform bills, sponsored by House Republican committee and subcommittee chairmen, had a common theme: making health insurance more affordable and easier to obtain. These were issues Democrats attempted to address in 1994. Although the Republican leadership was leery of addressing these issues again, they felt compelled to act because health insurance costs were high and millions of Americans were without insurance. Poll after public opinion poll ranked health reform high on the list of concerns, along with crime. (MacPherson, 1995, p. 945)

The early Republican bills were the Basic Health Care Reform Act, the ERISA Targeted Health Insurance Reform Act, and the Bliley-Bilirakis Plan.

1. The Basic Health Care Reform Act

This bill increased access to insurance for individuals and small companies. It required insurance companies to offer health insurance, with a guarantee of renewal, to all individuals and small companies who could pay the premiums. It also prevented insurance restrictions due to pre-existing conditions.

Insurance companies were required to offer at least two plans: a standard benefits package with a low deductible and a high deductible plan. People with high deductible plans could set up Medical Savings Accounts (MSAs), similar to

Individual Retirement Accounts (IRAs). Individuals could make pretax contributions to these plans, from which they would pay their deductible. MSAs were designed for high deductible insurance plans, those low premium plans which require individuals to pay large out of pocket costs before insurance coverage starts. (MacPherson, 1995, p. 945)

Finally, the bill changed the medical malpractice system, capping at \$250,000 the non-economic damages that could be recouped in a lawsuit. (MacPherson, 1995, p. 945)

2. ERISA Targeted Health Insurance Reform Act

This bill increased the number of small business owners offering employees health insurance. It accomplished this by making health insurance more affordable.

Allowing small businesses to form health purchasing co-operatives with individuals and small employers increases their bargaining power with insurance companies. This ultimately lowers prices. The bill removed legal barriers that precluded small business owners from joining health purchasing co-operatives. Additionally, prices were reduced by removing state-mandated minimum health benefits packages. (MacPherson, 1995, p. 945)

3. Bliley-Bilirakis Plan

This bill combined the provisions of the two other bills into one plan. It included provisions for MSAs, incremental insurance reforms, and medical malpractice changes.

C. HEALTH REFORM IN THE 104th CONGRESS

With no clear favorite among the early Republican proposals, House Speaker Newt Gingrich (R-Ga.) appointed a health care group to review the options and issues. Although the proposed measures had bipartisan support in 1994 (during the 103rd Congress), the new faces in the 104th Congress promised to make for a harder sell. The 104th Congress was far more conservative. Bills emphasizing insurance reforms required additional government regulation. This breached the ideological inclinations of many newly elected Republicans.

Additionally, deficit reduction fever ran rampant through Congress in 1995. Any serious health care proposal would have to be deficit neutral. Although it was believed that the three Republican bills would have little or no budgetary impact, they never gained momentum in the House. Thus they were never scored by CBO. To further complicate the process, Republican congressional aides stressed that staff growth had been modest since the Republicans gained the House majority. Thus there was not adequate staffing to simultaneously address health care issues and the budget reconciliation process. (MacPherson, 1995, p. 946)

Hope for reform lay in the Senate. Although health care reform was part of the Senate's version of the "Contract with America," the chamber was slow to move on the issue. It was widely believed that Senate Majority Leader Bob Dole (R-Kan.) would write the Republican health care reform bill, in conjunction with his bid for the Republican

Presidential nomination. However, in late March 1995, Senator Dole countered this belief when he said, "I'll be working on it, but I won't be writing it all myself" (MacPherson, 1995, p. 946).

1. Kassebaum-Kennedy Bill

The Senate unveiled its attempt at health care reform in late July 1995. The Health Insurance bill (S 1028) sponsored by Senators Nancy Landon Kassebaum (R-Kan.) and Edward M. Kennedy (D-Mass.) had 12 cosponsors, cutting a wide ideological swath in the Senate. This cross-section of support raised hopes for modest health care reform. The bill limited the ability of insurance companies to withhold medical coverage from people with pre-existing conditions to no more than 12 months, and made it easier for workers to get and maintain coverage. The provision guaranteeing coverage made it easier for workers to change jobs or start their own businesses without losing health insurance. In health care circles, this attribute is known as "portability." (Fraley, 1995, p. 2191)

The Senate Labor and Human Relations Committee unanimously approved the Health Insurance bill (S 1028) on August 2, 1995. This bill included the following provisions.

The bill prohibited insurers and employers from denying or limiting a worker's coverage under a group health plan for more than 12 months because of a pre-existing medical condition diagnosed or treated within the last six months. After the 12 month period, no pre-existing condition limits

could be imposed, even if the person changed jobs or insurance plans. The same protection was provided to individuals who switched from a group to an individual plan. (Fraley, 1995, p. 2191)

After 18 months of group health insurance coverage, workers were guaranteed access to individual insurance plans. Additionally, insurers were required to renew group and individual policies as long as premiums had been paid and the policy holder had not received coverage through deception. (Fraley, 1995, p. 2191)

The bill created incentives for small businesses and individuals to form health insurance coalitions and negotiate with providers. Forming health insurance purchasing coalitions would allow smaller players in the health care market to negotiate on an equal basis with large companies. (Fraley, 1995, p. 2191)

Finally, the bill certified continuing coverage to disabled workers and their families. (Fraley, 1995, p. 2191)

2. Post Committee Action

After the Senate Labor and Human Resources Committee approved the Health Insurance bill (S 1028) on August 2nd, it stalled in the Senate. Senate inaction reflected the more pressing matters occupying the Senate leadership, i.e., FY 1996 reconciliation legislation.

The health bill languished within the Senate until after reconciliation failed in March 1996. In April 1996, the bill grabbed the full attention of the congressional

leadership of both parties. This bill represented the last best hope for modest health care reform in the 104th Congress.

On April 23rd, 1996, the Senate unanimously passed the Health Insurance bill (HR 3103 formerly S 1028). However, the overwhelming vote of 100-0 masked the controversy and political maneuvering associated with the bill.

Prior to the Senate vote, Senate Majority Leader, Bob Dole (R-Kan.) attempted to insert a controversial provision providing for MSAs into the bill. This provision was defeated by a vote of 52-46. Five Republicans--including bill sponsor Nancy Kassebaum, the junior senator from Kansas--voted with a united block of Democrats to remove MSAs from the Dole amendment.

This defeat did not end the controversy surrounding MSAs. The House version of the bill included provisions for MSAs, thus providing Dole an opportunity to prevail in conference. Dole clearly had the upper hand in conference. He had the support of House conferees, and a majority of Senate conferees, whom he could select. (Langdon, 1996, p. 1170)

Proponents of MSAs, (mostly Republicans) argued that the accounts restrained costs by making consumers more prudent with their health care dollars. This awareness could force providers to be more competitive and cost effective in their services. (Fraley, 1995, p. 2375)

Critics, mostly Democrats, argued that the accounts appealed more to the wealthier and healthier segment of the

population. The sicker and poorer segment of the population would remain in traditional coverage, thus causing premiums to increase. Pete Stark (D-Calif.) argued that,

MSAs are simply a scheme to transfer money from sick people to healthy people and from those in lower tax brackets to those in higher brackets. And worse, they undermine the entire health care system by making health insurance unaffordable for those who are likely to be sick. (Fraley, 1995, p. 2375)

The President was counted among the critics of MSAs. The President's chief of staff, Leon Panetta, and Vice President Al Gore, said the President would veto any legislation containing MSAs.

The issue of MSAs seemed destined to derail the Health Insurance bill. Through procedural motions Democrats, led by Senator Edward E. Kennedy (D-Mass.), refused to allow Senator Dole to appoint conferees. Senator Kennedy was adamant that Dole name conferees reflecting the Senate's views on the issue, not the House's. Without assurances from Dole not to stack the conference, Democrats would prevent the conference from officially beginning.

On July 25th, more than a month after Senator Dole retired from the Senate to pursue presidential ambitions, a compromise was reached. With a handshake between a liberal senator and a conservative House member, the Congress was positioned to achieve something that had eluded it for years: health insurance reform. Senator Kennedy reached agreement with Representative Bill Archer (R-Texas),

chairman of the House Ways and Means Committee, on a pilot program for MSAs. Under the agreement, MSAs would be available to a limited population for four years, after which Congress would vote to expand eligibility to everyone. After this compromise, Senator Kennedy allowed the naming of Senate conferees.

The agreement was significant, for it cleared the last major hurdle to health insurance reform. The conference committee submitted final legislation which was approved by both Houses of Congress, and sent to the President for signature eight days after the agreement.

3. CBO Scoring

CBO analysis of the Conference Report on HR 3103, the Health Insurance Portability and Accountability Act of 1996, better known as the Kassebaum-Kennedy bill was completed August 1st, 1996. The next day both the House and Senate approved and sent the legislation to the President for signature. Although it was assumed the bill would be deficit neutral, it had not been officially scored (by CBO) until the day before House and Senate approval. CBO and the Joint Tax Committee estimated that the legislation would reduce the federal deficit by \$52 million in 1996 and by \$5.2 billion over the period 1996-2002 (see Table 7). Thus, unlike earlier health care reform efforts (during 103rd Congress) the Kassebaum-Kennedy bill was expected to reduce the deficit.

	1996	1997	1998	1999	2000	2001	2002	96-02
Deficit	\$-52	\$-275	\$79	\$-773	\$-1346	\$-1428	\$-1454	\$-5249

Table 7. Deficit Effects of Kassebaum-Kennedy bill, in millions of dollars.

Source: CBO, August 1, 1996.

D. CONCLUSIONS

It took Congress well over a year from the time Kassebaum and Kennedy first introduced their bill until they finished work on what was viewed as a widely popular measure. The success of Kassebaum-Kennedy was in part due to the failure of the Clinton health care reform initiative. Determined not to make the same mistakes and repeat history, Senators Kassebaum and Kennedy put together a simple plan based on the ideas which had garnered bipartisan support during the health care debates of 1993-1994. They fought to keep extraneous attachments from the bill, and for a while were successful. The bill sailed through their committee on a unanimous vote August 2nd, 1995. Thereafter it stalled, enduring political infighting, presidential campaign politics, and powerful interest group opposition. (Langdon, 1996, p. 2197)

Having failed to pass health care reform two years earlier, President Clinton was eager to associate himself with the Kassebaum-Kennedy bill. Clinton prominently backed the plan in his January 23rd, 1996 State of the Union address, raising the bill's profile and placing pressure on the Republicans to act. This pressure led Republican

leaders in the House to piece together three earlier bills into one measure, similar to the Senate bill. (Langdon, 1996, p. 2200)

It took seven months after committee approval for the bill to reach the Senate floor. Once it arrived, it again fell victim to presidential campaign politics and partisan fighting, with an attempt to add a MSA amendment. The resulting partisan bickering caused the bill to languish an additional three months, before a compromise solution could be reached. In the end, both parties compromised a little to craft legislation acceptable to both ideological camps. After the bruising budget impasse between Congress and the President, reform legislation was considered a necessity for those lawmakers seeking reelection in November 1996.

The new law, named principally for its chief sponsors, largely incorporated health reform ideas on which both parties had agreed since the Bush Administration. The bill's main accomplishment restricted the ability of insurance companies to deny coverage due to pre-existing health problems. (Zaldivar, 1996, p. 5A)

Although it did not help the more than 40 million uninsured Americans, it provided greater protection for millions of workers. A GAO study estimated that "about 21 million people would be able to get coverage because of the pre-existing conditions clause, and about four million people could use the portability guarantee to change jobs without fear of losing their health coverage" (Fraley, 1995, p. 2191).

V. SUMMARY AND CONCLUSIONS

The collapse of the Clinton health care reform initiative and the Republican electoral victory in 1994 ended the 60 year old debate over the feasibility of a federally financed health care system for all Americans. The Committee for Economic Security, which designed the Social Security Act of 1935, had considered including national health insurance in the legislative package. However, national health insurance was omitted in the end for fear of jeopardizing two more important and immediate goals - an old-age retirement system and unemployment insurance. The enactment of Medicare and Medicaid in 1965 was widely viewed as continuing the unfinished vision of national health insurance. When President Clinton proposed the Health Security Act in 1993, after 30 years without major action, national health care again looked to be within the realm of possibility. (Aaron, 1996, p. 35)

In the spring of 1993, all the elements seemed to be in place for reforming health care. There was a growing national consensus that something had to be done about rising health care costs. Public opinion polls showed that 80 to 85 percent of Americans thought there was a health care crisis, and that the system needed reconstructive surgery. More important, there was a new President who had successfully campaigned for health care reform, and wanted to deliver on this promise. He was joined by Democratic

congressional leaders, who had spent a long time waiting for a Democratic President to exercise the possibilities of an activist government. (Toner, 1995, p. 30)

There are many reasons for what turned the health care reform drive of 1993 into the legislative train wreck of 1994. The President made a series of strategic miscalculations. He pushed independently for an all or nothing plan of universal coverage rather than crafting a bipartisan policy. The Administration's mysterious health care task force, chaired by First Lady Hillary Rodham Clinton, met and devised the Health Security Act in closed door session. They delivered a politically tone-deaf plan. Time also proved to be a killer of health care. By presenting the plan to Congress late in the legislative session (October 1993), the Administration left congressional leaders less than a year to craft suitable reform legislation. (Toner, 1995, pp. 31-33)

The President, a centrist Democrat, believed he could bridge the tensions between the liberal and conservative factions of the Democratic party. This centrist philosophy may in part explain the complex health reform plan the Administration advanced. The plan tried to appease both factions; provide universal coverage to every American - clearly a goal of the liberal side - while avoiding the appearance of direct government involvement in financing and running the new health care system - a major concern of the conservative side. Because the plan had been crafted to appease both Democratic factions, without relying on

Republican support, it was immensely complex and confusing. In this atmosphere, the Republican party could easily convince the American people that the plan represented a tremendous federal tax and spend policy, and a government takeover of one-seventh the American economy. (Toner, 1995, pp. 31-32)

The demise of health care reform in the 103rd Congress had less to do with the deficit implications of the various bills than with the politics behind the reform process. Of the eight bills considered and scored by CBO, six would have decreased the cumulative deficit over a ten year period; two bills, including the President's bill, would have increased the cumulative deficit. Of these eight bills, only two were debated and reported out of committee and one was briefly debated by one of the full houses of Congress. The deficit implications of these bills does not appear directly responsible for their limited support. The deficit impact had more of an indirect effect. In an effort to reduce the deficit, most of the health reform bills included stiff provisions for containing costs and increasing revenues. These provisions, although reducing the deficit implications, eroded support from congressional members who viewed them as adversely affecting their constituents or the status quo.

In 1994, the Republicans seized control of both houses of Congress and immediately embarked on a journey to balance the budget by the year 2002. Their goal was to balance the budget, return a huge tax reduction to the

American people, and not touch Social Security or defense. With over half of what the federal government spends exempt from cuts, attention shifted to savings from the two government health care programs: Medicare and Medicaid.

These same two programs, according to CBO, were fueling future growth in federal deficits. Rising at an annual rate of about 10 percent, total Medicare and Medicaid outlays were expected to double by 2005. This growth was unsustainable in a budget predicated on reducing both the government and the tax burden on the American people. At this rate of growth, CBO estimated that Medicare and Medicaid spending combined would nearly equal total discretionary spending in ten years, or exceed it if discretionary spending were not allowed to keep pace with inflation. (CBO, Aug 1995, pp. 22-27)

In their quest to hold down the growth rate of Medicare, the Republican budget replaced the open ended guarantee of national coverage to a defined contribution health care program. They believed that only by changing Medicare to a defined contribution could Congress control costs, and ultimately future deficits.

Among the many proposals to reduce the federal government's share of Medicaid, the one gaining the most momentum was capping Medicaid spending. By capping spending at a rate substantially less than 10 percent growth and turning the program into block grants for the states, the government would effectively convert the program into a defined contribution plan.

The Democrats viewed the Republican agenda as a step toward reversing the gains they had made on the road to national health care. With little input into the budget debate and priorities, the Democrats crafted a policy of demagoguing the Republican's Medicare plan. Using the media, they effectively put the Republicans on the defensive with adds designed to convince elderly Americans that the Republican policies would savage the program, removing the health care safety net the elderly had "earned."

Late in the 1995 legislative session, Republicans and Democrats worked together to craft a health insurance reform bill incorporating provisions which had bipartisan support during the 1994 health reform debates. The bill, sponsored by Senators Kassebaum and Kennedy and 12 cosponsors, cut a wide ideological swath in the Senate. For the first time Democrats and Republicans were working in harmony to craft an insurance reform bill that the American people considered necessary. The bill sailed through the Senate Labor and Human Resources Committee with complete bipartisan support.

However, the bill encountered turbulent weather once it was exposed to the acrimonious atmosphere of the full Senate. There the bill languished for over seven months, caught in the political jockeying for the upcoming presidential elections. The debate over Medical Savings Accounts (MSAs) looked like it would derail this final attempt at health care reform. The issue had strong Republican support, but was considered to be a poison pill to Democrats and the President. Compromise on the issue was

paramount if the legislation was to ever reach a House-Senate conference committee. With a single handshake between a liberal senator and conservative House member, a compromise was reached between the liberal wing of the Democratic party and the conservative wing of the Republican party. The Congress was positioned to achieve something that had eluded it for years: health insurance reform.

The Kassebaum-Kennedy bill is significant. For the first time in over four years Democrats and Republicans were able to work together to craft a health reform bill. The bill had a nominal impact on beneficiaries, providers and the deficit. Thus, it was able to garner support from both ideological camps (the liberal and conservative wings of both parties). The previous two attempts (the 1993-94 Clinton health care reform initiative and the 1995 Republican Medicare and Medicaid initiatives) had substantial impacts on beneficiaries, providers and the deficit, and could not attract the necessary support for passage. The implication is that health care legislation which portends minimal impact on beneficiaries, providers and the deficit is much more likely to garner the support necessary for compromise and passage; legislation which has a much broader effect will not receive the same consideration, in the absence of overwhelming public support.

A. CONCLUSIONS

Political interest in health care policy and financing will remain a hot issue for at least three reasons. First, public pressure to balance the budget will keep Medicare and Medicaid in the public spotlight. These two programs represented more than 22 percent of federal spending in 1996 (excluding interest on the debt), and are projected to grow to more than 27 percent of federal spending by the year 2002. (CBO, Aug 1995, p. 2) Additionally, the increase in spending on Medicare and Medicaid, as a percentage of GDP, accounts for all the projected increase in the federal deficit between 1996 and 2002. (CBO, Aug 1995, p. 2)

Second, the retirement of the baby boom generation, starting in 2010, portends large increases in federal spending for Medicare and Medicaid.

Third, an inexhaustible flood of new medical technologies and techniques will continue to put financial pressure on everyone who pays for health insurance, including state and federal governments. Real health care spending has grown more than 5 percent annually over the last four decades.

For these three reasons the issue of health care financing will not go away. In the aftermath of the 1994 health care reform train wreck, and the 1995 Republican balanced budget failure, the landscape of the health care reform effort has changed. (Aaron, 1996, p. 35)

The American political system is very complex and dynamic. In this type of system, transformational change is

extremely difficult if not impossible to manage without overwhelming public support or crisis. The political system favors a policy of incremental change. Change, although achievable in a partisan atmosphere, is easier to effect in a truly bipartisan atmosphere of debate and compromise. Without bipartisan support, the minority will tend to undermine the majority proposals through demagoguery and use of the media.

The deficit will continue to shape and define any and all future health care policy debates. Public opinion polls lend credence to the Republican claim that the deficit must be controlled and the budget balanced. Ultimately, big changes in Medicare are unavoidable. Medicare covers 12.8 percent of the U.S. population; by 2030 it is expected to cover nearly 20 percent of the population. No conceivable improvement of system efficiency will support 20 percent of the population on the same tax base which currently supports 12.8 percent of the population. (Starr, 1996, p.27)

This is especially pertinent considering the change in the demographics which make up this tax base. In 1995 there were 144 million workers supporting 37 million Medicare beneficiaries, translating to 3.9 workers per beneficiary. By the year 2030, there will be only 2.2 workers per beneficiary; by 2060 this ratio will drop to two workers per beneficiary (see Figure 13). (Langdon, 1997, p. 489)

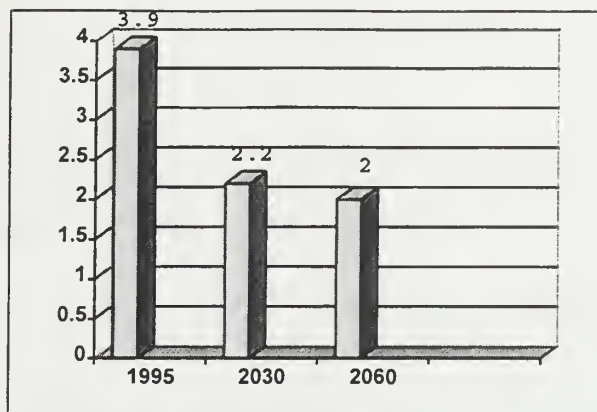


Figure 13. Workers per Beneficiary.
Source: 1996 Annual Report of the
Board of Trustees of the Hospital
Insurance Trust Fund.

B. RECOMMENDATIONS FOR FURTHER RESEARCH

Several important areas of health care reform remain to be explored. First, there is the role of the federal government in the demise of the uncompensated care subsystem. Uncompensated care involves cross subsidies to support the uninsured population. Compensation for this segment of the population comes from insured patients who pay more than the full cost of their care.

Second, future policy reform alternatives that could slow the growth of Medicare and Medicaid should be analyzed. These initiatives would have to consider possible changes in private health insurance financing and the fears the elderly experience anytime the federal government looks to reform Medicare and Medicaid.

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